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ABSTRACT

Contained are the proceedings of the September 13, 1976, hearing before the House of Representatives subcommittee on health and the environment on Bills H.R. 12937, H.R. 14309 and H.R. 14822, identical bills to establish a national system of maternal and child health care, and H.R. 14497, a bill to establish a national health insurance system for maternal and child health care. Included are the texts of the bills, statements by witnesses, and additional materials submitted for the record. (SB)

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MATERNAL AND CHILD HEALTH CARE ACT—1976

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SUPPLEMENTAL HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON
INTERSTATE AND FOREIGN COMMERCE
HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

SECOND SESSION

ON

H.R. 12937, H.R. 14309, and H.R. 14822
(identical bills)

BILLS TO ESTABLISH A NATIONAL SYSTEM OF MATERNAL
AND CHILD HEALTH CARE

AND

H.R. 14497

A BILL TO ESTABLISH A NATIONAL HEALTH INSURANCE
SYSTEM FOR MATERNAL AND CHILD HEALTH CARE

SEPTEMBER 13, 1976

Serial No. 94–117

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MATERNAL AND CHILD HEALTH CARE—1976

MONDAY, SEPTEMBER 13, 1976

House of Representatives,
Subcommittee on Health and the Environment,
Committee on Interstate and Foreign Commerce,
New York, N.Y.

The subcommittee met, pursuant to notice, at 10 a.m., in room 305, 26 Federal Plaza, New York City, N.Y., Hon. James H. Scheuer presiding [Hon. Paul G. Rogers, chairman].

Mr. Scheuer. Good morning.

I am Congressman Jim Scheuer. We are honored today to have Senator Jacob Javits with us. We are cosponsors of this maternal and child health care bill. I will speak for a moment or two and then I will turn the program over to the senior Senator from our State and then we will commence the witness list.

The state of maternal and child health care in this country is a shame and a disgrace. With all of our riches, with all of our technological capability, with all of our resources we rank about 15th in the world in child care and infant mortality, ranking somewhere between East Germany and Hong Kong.

In terms of maternal care, about a third of the pregnant women in our country receive grossly inadequate maternity care and in terms of the children in our country we have grossly failed to put our money where our mouth is when it comes to our pretentions that the kids are the future of our country, the kids are our treasure, the kids are our greatest and most valued resource.

Kids constitute about a third of our population but we spend only 10 percent of our money on child care. About a third of our preschool children get no inoculation for polio and about 40 percent of our preschool children get no inoculation against rubella. A full 25 percent of our kids up to age 15 or 16 have never had health care or have never seen a doctor or dentist of any kind. Now that is a shocking state of affairs.

Approximately half of our kids age 15 have never seen a dentist and two-thirds of the kids age 15 in the poverty category have never seen a dentist. Fifteen percent of the kids who come up for the draft, the noncollege bound kids, are so deficient that they fail to pass the draft health standards.

In addition to this gross inadequacy on a national basis the inadequacy is even more askewed when you consider the disparity in the racial statistics. The incidence of infant mortality for minorities, for blacks, for Puerto Ricans is almost twice that for white children which makes the shame and the disgrace even more of a moral nature. We have long since passed the point when we should be considering a systematic and orderly way of delivering good health care to every American child and every prospective mother and this bill does that.

I hope that many, if not most of you are familiar with the details of the bill. What it does is to look at the spectrum of health care services which are unplanned, uncoordinated, and splintered and proposes instead a system of health care that is planned, that is coordinated, and that is comprehensive. We have left it to chance far too long and the services that we have provided for poor kids have generally turned out to be poor services; grossly inadequate to the need.

To give you one specific example, in the EPSDT program—the early periodic screening diagnosis and treatment program—you find a perfect symbolism of the failure of the Federal Government to assume its proper responsibility. Although the program is 5 years old, of the 13 million children in the preschool category who should be receiving early periodic screening diagnosis and treatment less than 2 million—less than 2 million out of 13 million kids—have been screened. Furthermore, from those screened, very few receive the followup treatment often indicated. In other words, the follow up is inadequate to the need as is the screening process itself.

The Federal Government has failed in its role to provide this most essential of all human services, has grossly failed to be the leveler as between States that can and the States that cannot deliver adequate and appropriate health services. The time has come when we have to take a comprehensive look at the health care needs of mothers and children and to take what action is necessary. We think the time is now.

We have experimented in national health delivery programs. We have experimented for a decade with the medicaid program for the poor and the medicare program for the elderly and some of its problems have become very evident, especially in the areas of quality and cost controls. In this bill we have attempted to meet both the problems of quality and cost control. Above all, we have tried to meet the problem of a vacuum of caring, of a vacuum of concern, of a vacuum of involvement in the welfare of the mothers and children of this country.

We have a number of very distinguished House sponsors of this bill. We have not yet sent this bill to the whole House of Representatives for their perusal, we have sent it only to selected members of a few of the committees involved. We have the sponsorship of Congressman Dan Flood, of Pennsylvania, the chairman of the Labor-HEW Appropriations Subcommittee, and a number of other influential Members. Of course, on the Senate side we are honored and delighted to have the sponsorship of Senator Javits as the prime Senate sponsor and along with him Senators Cranston and Brooke. This bill is in the mainstream of consideration, it is in the stream of commerce let us say.

We have had a day of excellent hearings in Washington when we heard from former Secretary of HEW Wilbur Cohn who was one of the great supporters of this bill from its earliest stages and who really helped us piece it together. This is our second day of hearings [1] and we are very delighted to have a very distinguished group of witnesses present.

Without objection, the text of H.R. 12937, H.R. 14309, H.R. 14822, and H.R. 14497 will be placed in the record at this point.

[Testimony resumes on p. 177.]

[The bills referred to follow:]

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[1] For first day of hearing see "Maternal and Child Health Care Act," hearing before the Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce, held on June 16, 1976, Serial No. 94-98.

[H.R. 12937, introduced by Mr. Sheuer on March 31, 1976;
H.R. 14309, introduced by Mr. Scheuer (for himself, Ms. Burke of California, Mr. Conte, Ms. Holtzman, Mr. Maguire, Mr. Pepper, Mr. Rangel, Mr. Roybal, and Mr. Stokes) on June 10, 1976; and
H.R. 14822, introduced by Mr. Scheuer (for himself, Mr. Conyers, Mr. Krebs, Mr. Charles H. Wilson of California, Mr. Bingham, Ms. Chisolm, Mr. de Lugo, Mr. Hawkins, Mr. Ottinger, Mr. Richmond, Mr. Rosenthal, Mr. Glood, Mr. Badillo, Mr. Drinan, Mr. Diggs, Mr. Miller of California, Mr. Zeferetti, Mr. Fraser, and Mr. Mitchall of Maryland) on July 22, 1976,

are identical as follows:]

A BILL

To establish a national system of maternal and child health care.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act with the table of contents may be cited as the "Maternal and Child Health Care Act".

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PART A—GENERAL PROVISIONS

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Sec. 202. Standards for qualified institutions.

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Sec. 214. Covered home health care services.
Sec. 215. Covered diagnostic services.
Sec. 216. Covered rehabilitative, social, and mental health services.
Sec. 217. Covered drugs and biologicals.
Sec. 218. Covered devices, appliances, and equipment.

Part C—Maternity Benefits

Sec. 221. Covered professional services.
Sec. 222. Covered inpatient hospital services.
Sec. 223. Covered diagnostic services.
Sec. 224. Covered drugs and biologicals.
Sec. 225. Covered devices, appliances, and equipment.

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Sec. 233. Covered support services.

TITLE III—ADMINISTRATION AND METHOD OF PAYMENT OF BENEFITS

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PART C—PAYMENT FOR COVERED INSTITUTIONAL SERVICES

Sec. 321. General provisions.
Sec. 322. Approval of prospective rate schedules.

PART D—PAYMENT FOR DRUGS, DEVICES, AND SPECIAL POPULATION BENEFITS

Sec. 331. Definitions.
Sec. 332. Payment for covered drugs and devices.
Sec. 333. Payment for special population benefits.

TITLE IV—FINANCING THE MATERNAL AND CHILD HEALTH PROGRAM

PART A—FUNDS FOR SUPPORT OF THE MATERNAL CHILD HEALTH PROGRAM

Sec. 401. Authorization of appropriations.
Sec. 402. Payroll and self-employment taxes.
Sec. 403. Technical and conforming amendments.

PART B—MATERNAL AND CHILD HEALTH TRUST FUND

Sec. 411. Creation of the Trust Fund.
Sec. 412. Funding of Trust Fund.
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TITLE V—PENALTIES, EFFECTIVE DATES, AND TECHNICAL AMENDMENTS

Sec. 501. Penalties.
Sec. 502. Effective dates.
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FINDINGS AND DECLARATION OF PURPOSE

SEC. 2. (a) The Congress finds and declares that—

(1) the mothers and children of this Nation are the foundation of its future strength, productivity, and prosperity;

(2) adequate health care for mothers and children is essential to safeguard this precious resource; and

(3) adequate medical care for pregnant women and children has the greatest potential for improving the health status of the general population.

(b) The purpose of this Act is—

(1) to establish a system of national health care benefits for children and pregnant women residing in the United States;

(2) to increase the access of such individuals to health care, to enhance its quality, and to emphasize the prevention of disease as well as the treatment of illness; and

(3) to improve the efficiency and the use of resources and to restrain the increasing costs of maternal and child health care, while providing fair and reasonable compensation to those who furnish it.

FREE CHOICE BY PATIENT AND PRACTITIONER

SEC. 3. The administration of this Act shall not interfere with the freedom of any physician or any patient to choose where and how they will give or receive health care. Neither the Secretary, the Board, nor any of their agents, shall make medical decisions with respect to a patient's health care; this function is reserved solely to the physician and his peers.

OBSERVANCE OF RELIGIOUS BELIEFS

SEC. 4. Nothing in this Act shall be construed to authorize the Secretary or the Board (or any of their agents or employees) to compel any person to undergo any medical screening, examination, diagnosis, or treatment, or to accept any other health care services provided under this Act for any purpose.

TITLE I—GENERAL PROVISIONS AND ADMINISTRATION

PART A—GENERAL PROVISIONS

DEFINITIONS

SEC. 101. For the purposes of this Act, the term—

(1) "Secretary" means the Secretary of Health, Education, and Welfare;

(2) "Board" means the Maternal and Child Health Board established by section 111;

(3) "child" means an individual from the time of birth to the age of eighteen years;

(4) "Council" means the National Maternal and Child Health Council established by section 121;

(5) "covered service" means a health care service or item described in title II for which payment may be made in accordance with title III of this Act; and

(6) "alien lawfully admitted for permanent residence" includes an alien permanently residing in the United States under color of law and an alien who is lawfully present in the United States as a result of the application of section 203 (a) (7) or section 212 (d) (5) of the Immigration and Nationality Act; and

(7) "State" includes the District of Columbia, the Commonwealth of Puerto Rico, and the territory of the Virgin Islands, Guam, and American Samoa.

ELIGIBILITY FOR BENEFITS

SEC. 102. (a) Every individual—

(1) who is a citizen of the United States or an alien lawfully admitted for permanent residence, and

(2) who is a child or who is pregnant,

shall be eligible to have payment made for health care services received by such individual in accordance with the provisions of this Act.

(b) Any female individual who is described in subsection (a) (1) shall be eligible to have payment for health care services received by such individual in order to determine whether or not such individual is pregnant, in accordance with the provisions of this Act.

PART B--ADMINISTRATION

ESTABLISHMENT OF THE MATERNAL AND CHILD HEALTH BOARD

SEC. 111. (a) There is hereby established in the Department a Maternal and Child Health Board to be composed of three members to be appointed by the President, by and with the consent of the Senate. During his term of membership on the Board, no member shall engage in any other business, vocation, or employment. Not more than two members of the Board shall be members of the same political party.

(b) Each member of the Board shall hold office for a term of five years except that—

(1) a member appointed to fill a vacancy occurring during the term for which his predecessor was appointed shall be appointed for the remainder of that term, and

(2) the terms of office of the members first appointed shall expire, as designated by the President at the time of their appointment, at the end of 1, 3, and 5 years, respectively, after the date of enactment of this Act.

A member who has served for two consecutive five-year terms shall not be eligible for reappointment until two years after he has ceased to serve.

(c) The President shall designate one of the members of the Board as Chairman of the Board.

DUTIES OF THE BOARD

SEC. 112. (a) In addition to the specific duties given the Board under this Act, the Board shall—

(1) except as specifically provided under this Act, have the duty of administering titles II and III of this Act (relating to nature and scope of benefits and administration and method of payment of benefits under this Act), and

(2) have the general duty of continuously studying the operation of this Act and of the most effective methods of providing comprehensive personal health services to mothers and children in the United States, and of making recommendations on legislation and matters of administrative policy with respect thereto.

(b) The Board shall make an annual report to the Congress on the administration of the functions with which it is charged. The report shall include, for periods prior to the effective date of health benefits, an evaluation by the Board of the progress in preparing for the initiation of benefits under this Act, and for periods thereafter, an evaluation of the operation of the Act, of the adequacy and quality of services furnished under it, of the adequacy of compensation to the providers of services, and of the costs of the services and the effectiveness of measures to control such costs.

(c) The Secretary shall make available to the Board all information available to him, from sources within the Department or from other sources, pertaining to the functions and duties of the Board.

EXECUTIVE DIRECTOR, EMPLOYMENT OF STAFF, AND DELEGATION OF AUTHORITY

SEC. 113. (a) There is hereby established the position of Executive Director of the Maternal and Child Health Board. The Executive Director shall be appointed by the Board with the approval of the Secretary and shall perform such duties in the administration of this Act as the Board assigns.

(b) (1) The Board is authorized to employ such individuals, in accordance with the provisions of title 5, United States Code, as may be necessary to carry out its functions under this Act.

(2) To the extent it deems it consistent with the purposes of this Act and its duties under this Act, the Board may employ such hearing examiners as it determines to be necessary to promote the resolution of disputes over—

(1) an individual's eligibility for covered benefits under section 102;

(2) the qualifications of institutions, under section 202;

(3) the appropriateness of a fee payment schedule, prospective rate schedule, wholesale cost schedule, or dispensing fee schedule established under title III;

(4) the reasonableness of payments for special population benefits, under section 333; or

(5) violation of an agreement required under section 307 or the requirements of title III under section 307.

(c) The Board is authorized to delegate to the Executive Director, to any other officer or employee of the Board, or, with the approval of the Secretary, to any other officer or employee of the Department, any of its functions or duties under this Act, other than the issuance of regulations.

REGULATIONS OF AND SUBPENAS BY THE BOARD

SEC. 114. (a) The Board shall prescribe such regulations as may be necessary to carry out its duties under this Act.

(b) (1) For the purpose of any hearing, investigation, or other proceeding authorized under this Act, the Board may issue subpenas requiring persons any place in the United States to attend and testify as witnesses at the designated place of such hearing, investigation, or other proceeding, and to produce any evidence that relates to any matter under investigation or in question before the Board. Subpenas of the Board shall be served by anyone authorized by it by delivering a copy thereof to the person named therein, or by mailing a copy by registered mail or by certified mail addressed to such individual at his last dwelling place or principal place of business. A verified return by the individual so serving the subpena setting forth the manner of service, or, in the case of service by registered mail or by certified mail, the return post office receipt therefor signed by the person so served, shall be proof of service. Witnesses so subpenaed shall be paid the same fees and mileage as are paid witnesses in the district courts of the United States.

(2) In case of contumacy by, or refusal to obey a subpena duly served upon, any person, any district court of the United States for the judicial district in which such person charged with contumacy or refusal to obey is found or resides or transacts business, upon application by the Board, shall have jurisdiction to issue an order requiring such person to appear and give testimony, or to appear and produce evidence, or both; any failure to obey such order of the court may be punished by such court as contempt thereof.

FUNDS FOR THE EVALUATION OF THE MATERNAL AND CHILD HEALTH CARE PROGRAM

SEC. 115. (a) The Secretary shall allocate to the Office of Research and Statistics of the Social Security Administration an amount equal to one-tenth of 1 per centum of the total amount of payments made under this Act for the purpose of evaluating the operation of this Act and the impact of such operation on existing private health insurance programs.

(b) Not less often than annually, such Office shall report to the Secretary, to the Board, and to the Congress on the operation of this Act and shall include in such report any recommendations for changes in the operation of this Act.

PART C—ADVISORY COUNCIL

ESTABLISHMENT OF NATIONAL MATERNAL AND CHILD HEALTH COUNCIL

SEC. 121. (a) There is hereby established a National Maternal and Child Health Council, which shall consist of the Chairman of the Board, who shall serve as Chairman of the Council, and ten members, not otherwise in the employ of the United States, appointed by the Secretary, on recommendation of the Board, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, as follows:

(1) not less than six individuals who—

(A) are not engaged in and have no financial interest in the furnishing of any health services,

(B) are representatives of consumers of maternal and child health care services,

(C) are familiar with the health care needs of mothers and children, and

(D) are experienced in dealing with problems associated with the obtaining of maternal and child health care services; and

(2) not more than four individuals who—

(A) are outstanding in fields related to medical, hospital, or other health activities, or

(B) are representative of organizations or associations of professional health personnel.

(b) Each member of the Council shall serve for a term of five years, except that—

(1) any member appointed to fill a vacancy occurring during the term for which his predecessor was appointed shall be appointed for the remainder of that term; and

(2) the terms of members first appointed shall expire, as designated by the Secretary at the time of their appointment, two at the end of the first year, two at the end of the second year, two at the end of the third year,

two at the end of the fourth year, and two at the end of the fifth year after the date of enactment of this Act.

DUTIES OF COUNCIL

SEC. 122. (a) The Council shall—

(1) advise the Board on matters of general policy in the administration of this Act, in the formulations of regulations, and in the performance of the Board's functions and duties,

(2) study the operation of this Act and the use of maternal and child health care services under it, and

(3) recommend to the Board such changes in the administration of the provisions of the Act as it deems desirable.

(b) The Council shall make an annual report to the Board on the performance of its functions, including any recommendations it may have with respect thereto, and shall promptly transmit such report to Congress.

(c) The Council shall meet as frequently as the Board deems necessary, but not less than four times each year. Upon request of six or more members, it is the duty of the Chairman to call a meeting of the Council.

APPOINTMENT OF STAFF AND COMPENSATION

SEC. 123. (a) The Council is authorized to appoint such professional or technical consultants as may be necessary to carry out its duties.

(b) The Board shall provide such secretarial, clerical, and other assistance as the Council may require to carry out its duties under this Act.

(c) Members of the Council and technical or professional consultants, while serving or traveling on business of the Council, shall receive compensation at rates fixed by the Board, but not in excess of the equivalent of the daily rate paid under GS–18 of the general schedule under section 5332 of title 5, United States Code; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in Government service employed intermittently.

TITLE II—NATURE AND SCOPE OF BENEFITS

PART A—DEFINITIONS AND QUALIFICATIONS OF INSTITUTIONS

DEFINITIONS, GENERAL TERMS AND SERVICES

SEC. 201. For the purpose of this title and title III, the term—

(1) "physician" means a doctor of medicine, osteopathy, dentistry, or optometry who is legally authorized to practice his or her profession in the State in which he or she performs such functions;

(2) "physician extender" means a physician assist-

ant, dental auxiliary, nurse practitioner, or nurse midwife under the supervision of a physician whether or not performed in the office of such physician or at a place at which he or she is present if the individual may legally perform the services in the State in which the services are performed;

(3) "professional services" means medical services provided by a physician or physician extender and includes materials and supplies commonly furnished, without separate charge, by a physician or physician extender as an incident to the provision of such services;

(4) "preventive children's health services" means professional services the frequency and content of which are determined by the Board, after consultation with the Council, to be ordinarily necessary to maintain the health of a child and to prevent common illnesses, and may include medical and dental evaluations, immunizations, screening for vision and hearing defects, and appropriate health education;

(5) "inpatient services" means—

(A) bed and board;

(B) such nursing, medical, rehabilitative, and other services as are ordinarily furnished by a qualified hospital for the care and treatment of inpatients;

(C) such mental health services, including psychiatric and psychological services, only as are incident to the treatment of conditions other than psychosis;

(D) drugs, biologicals, blood and blood products, supplies, appliances, and equipment for use in a hospital for the care and treatment of inpatients; and

(E) such other diagnostic and therapeutic items and services ordinarily furnished by a qualified hospital, or by others by arrangement with such hospital, to inpatients.

(6) "home health services" means nursing services and home-making services, as defined by the Board;

(7) "diagnostic services" means tests for the purpose of providing information for the diagnosis, prevention, or treatment of any injury, disability, or disease or for the assessment of the health of an individual;

(8) "emergency medical care" means medical care for patients with a severe, life-threatening, or potentially disabling condition which requires medical intervention within minutes or hours after the onset of such condition; and

(9) "support services" means services described in section 233.

STANDARDS FOR QUALIFIED INSTITUTIONS

SEC. 202. For the purposes of this title and title III, the term—

(1) "qualified hospital" means a hospital which, as determined in accordance with section 203—

(A) provides diagnostic and therapeutic services to patients for a variety of medical conditions;

(B) maintains clinical records on all its patients;

(C) has bylaws in effect with respect to its staff of physicians;

(D) has taken steps to ensure that it will not discriminate on any ground unrelated to professional qualifications in the granting or maintaining of medical staff privileges;

(E) requires that every patient must be under the direct and personal care of a single physician;

(F) provides twenty-four-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;

(G) has a pharmaceutical and drug therapeutics committee which establishes policies for the selection, acquisition, and use of drugs;

(H) has in effect a hospital utilization review plan which meets the requirements of title XVIII of the Social Security Act;

(I) meets all applicable requirements of the laws of the State and of the locality in which it is situated; and

(J) meets such other requirements as the Board finds necessary in the interest of the health and safety of the individuals who are furnished services in such institution.

(2) "qualified pediatric unit" means a unit in a qualified hospital which, as determined in accordance with section 203—

(A) is a separate unit in the hospital for the exclusive use of children;

(B) contains at least twelve beds;

(C) has an annual occupancy rate of at least 70 per centum;

(D) has no restrictions on visiting hours for parents and guardians except as medically required; and

(E) has a reasonable and adequate arrangement for overnight accommodation of the parent, guardian, or adult friend of a patient under the age of seven years.

(3) "qualified obstetrical unit" means a unit in a

qualified hospital which, as determined in accordance with section 203—

(A) is a separate unit in the hospital for the exclusive use of obstetrical patients;

(B) has an average of at least—

(i) 500 deliveries annually if located in a rural area (as defined by the Board), or

(ii) 1,500 deliveries annually if not located in a rural area.

The Board may waive the required number of deliveries specified in subparagraph (B) (i) if it finds it in the best interests of the medical care of pregnant women in the area.

(4) "qualified nursing home" means an institution which, as determined in accordance with section 203—

(A) provides skilled nursing and related services to inpatients who are not being treated primarily for mental illness;

(B) has written policies, established and periodically reviewed by a group including at least one physician and at least one registered nurse, governing its furnishing of health services, including the dispensing and administering of drugs;

(C) has a full-time physician or full-time registered nurse supervising its furnishing of medical services;

(D) requires that every patient must be under the direct and personal care of a single physician;

(E) has a physician available to furnish emergency medical care;

(F) maintains clinical records on all its patients;

(G) has in effect a utilization review plan which meets the requirements of title XVIII of the Social Security Act;

(H) meets all applicable requirements of the laws of the State and of the locality in which it is situated;

(I) provides for examination of a patient by a physician within twenty-four hours of the time of his admission to it;

(J) provides for admission of a patient only after a certification by a physician that the patient requires care in such a facility; and

(K) meets such other requirements as the Board finds necessary in the interest of the health and safety of the individuals who are furnished services in such institution.

(5) "qualified home health agency" means an institution which, as determined in accordance with section 203—

(A) is a public or nonprofit organization, or subdivision thereof;

(B) provides skilled nursing related to patients in their homes;

(C) has written policies, established and periodically reviewed by a group including at least one physician and at least one registered nurse, governing its furnishing of services;

(D) has a full-time physician or full-time registered nurse supervising its furnishing of home health services;

(E) maintains clinical records on all its patients;

(F) meets all applicable requirements of the laws of the States and of the localities in which it furnishes services; and

(G) meets such other requirements as the Board finds necessary in the interest of the health and safety of the individuals who are furnished services in such institution.

(6) "qualified pathology laboratory" means a fa-

cility for the biological, microbiological, serological, chemical, immuno-hematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body, which meets all applicable requirements of the laws of the State and of the locality in which it is situated.

DETERMINATION OF QUALIFIED INSTITUTIONS

SEC. 203. (a) In determining the qualifications of an institution under section 202, the Board shall consult, pursuant to this section, with appropriate State agencies, recognized national listing or accrediting bodies, and health systems agencies (established pursuant to title XV of the Public Health Service Act).

(b) (1) The Board shall delegate, to the extent that the Board finds it appropriate, to a State health agency or other appropriate State agency (hereinafter in this subsection referred to as the "State health agency"), the function of determining whether or not an institution meets any or all of the qualifications of section 202.

(2) If the Board finds that accreditation of an institution by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association, or any other national accrediting body provides reasonable assurance that any or

all of the qualifications of section 202 are met, it may, to the extent it deems it appropriate, treat such institution or agency as meeting the qualification or qualifications with respect to which the Board made such finding.

(3) The Board may agree with the State health agency for such agency to survey—

(A) on a selective sample basis, or

(B) when the Board finds that a survey is appropriate because of substantial allegations of the existence of a significant deficiency or deficiencies, which, if found to be present, would adversely affect the health and safety of patients,

any institution whose qualifications under section 202 are reviewed under subsection (b) (2) or section 303 (a) (2) (A), and which has made an agreement with the Board pursuant to section 321 (b) (3).

(4) No later than sixty days after the completion, pursuant to paragraph (1) or (3), of a survey by a State health agency of the qualifications of an institution under this Act, the Board shall publish the findings of each such survey in a readily available manner.

(c) The Board shall pay the State health agency for the reasonable cost of performing functions authorized under subsection (b).

PART B—CHILDREN'S BENEFITS

COVERED PROFESSIONAL SERVICES

SEC. 211. (a) Except as provided in subsection (b), covered professional services shall include—

(1) preventive children's health services, and

(2) professional services for the diagnosis, treatment, or rehabilitation of a child following injury, disability, or disease.

(b) For the purposes of this section, covered professional services do not include—

(1) orthodontic services for children except for handicapping malocclusion;

(2) professional dental services for children under the age of four years;

(3) major surgery on a child not performed by a surgeon eligible or certified by a surgical specialty board;

(4) a tonsillectomy or adenoidectomy performed on a child without a second consultation by an independent physician as to the necessity for such surgery; and

(5) psychiatric services.

COVERED INPATIENT HOSPITAL SERVICES

SEC. 212. (a) Except as provided in subsections (b) and (c), covered inpatient hospital services shall include—

(1) inpatient services for a child of any age in any qualified hospital where a physician certifies, in accordance with regulations established by the Board, that the child requires emergency medical care;

(2) inpatient services for a child under the age of twelve years in a qualified pediatric unit; and

(3) inpatient services for a child of twelve years or older in a qualified hospital.

(b) For the purposes of this section, covered services do not include the services of a private duty nurse or attendant.

(c) Covered inpatient hospital services under this section are limited to 100 days of inpatient services annually.

COVERED NURSING HOME SERVICES

SEC. 213. (a) Except as provided in subsection (b), covered nursing home services shall include inpatient services for a child in any qualified nursing home.

(b) Covered nursing home services under this section are limited to 120 days of inpatient services annually.

COVERED HOME HEALTH CARE SERVICES

SEC. 214. (a) Except as provided in subsection (b), covered home health care services shall include home health care services furnished by a qualified home health agency, where a physician certifies, in accordance with regulations established by the Board, that such services are necessary for the health and welfare of a child.

(b) Covered home health care services under this section are limited to 120 days of home health care services annually.

COVERED DIAGNOSTIC SERVICES

SEC. 215. Covered diagnostic services shall include diagnostic services performed by a qualified pathology laboratory for a child who is not an inpatient in a hospital or in a nursing home.

COVERED REHABILITATIVE, SOCIAL, AND MENTAL HEALTH SERVICES

SEC. 216. (a) Except as provided in subsection (b), covered rehabilitative, social, and mental health services shall include—

(1) rehabilitative services, including physical therapy and speech therapy,

(2) social services, and

(3) mental health services, including psychiatric and psychological services,

furnished to a child who is not an inpatient in a hospital or nursing home, if furnished in a facility described in subsection (c), where a physician certifies, in accordance with regulations established by the Board, that such services are necessary for the health and welfare of a child.

(b) Covered rehabilitative, social, and mental health services under this section are limited as follows:

(1) rehabilitative services are limited to 60 visits, as defined by the Board, annually, and

(2) social and mental health services are limited to 60 visits, as defined by the Board, annually.

(c) A service described in subsection (a) is a covered service when furnished in a facility which—

(1) is run by a nonprofit or public organization, or subdivision thereof, and

(2) meets the applicable requirements of laws of the State and of the locality in which it is located.

COVERED DRUGS AND BIOLOGICALS

SEC. 217. (a) Covered drugs and biologicals shall include any drug or biological dispensed for use by a child who is not an inpatient in a hospital or nursing home, if—

(1) such drug or biological is required, by section 503 (b) of the Federal Food, Drug, and Cosmetic Act, to be dispensed only upon prescription of a physician; and

(2) such drug or biological is prescribed to be taken by such child for a period of longer than four weeks.

(b) Covered drugs and biologicals shall also include insulin dispensed for use by a child who is not an inpatient in a hospital or nursing home.

COVERED DEVICES, APPLIANCES, AND EQUIPMENT

SEC. 218. (a) Except as provided in subsection (b), covered devices, appliances, and equipment shall include—

(1) the dispensing of such devices for the correction of the vision or hearing of a child, and

(2) the dispensing of such other medical devices, appliances, and equipment for the treatment or rehabilitation of a child following injury, disability, or disease,

as a physician certifies, in accordance with regulations established by the Board, to be necessary for the health and welfare of such child.

(b) The Board may, by regulation, exclude from covered devices, appliances, and equipment under subsection (a) the dispensing of such devices, appliances, and equipment as the Board determines to be ineffective, unreliable, or not cost-justified in the treatment or rehabilitation of a child following injury, disability, or disease.

PART C—MATERNITY BENEFITS

COVERED PROFESSIONAL SERVICES

SEC. 221. Covered professional services shall include professional services—

(1) for the diagnosis and treatment of pregnancy, and

(2) for the diagnosis and treatment of any injury, disability, or disease during pregnancy, and

(3) for the diagnosis and treatment of any injury, disability, or disease related to pregnancy during the period of twelve weeks immediately following the termination of a pregnancy.

COVERED INPATIENT HOSPITAL SERVICES

SEC. 222. (a) Except as provided in subsection (b), covered inpatient hospital services shall include—

(1) inpatient services for a woman during pregnancy in any qualified hospital where a physician certifies, in accordance with regulations established by the Board, that the woman requires emergency medical care;

(2) inpatient services in a qualified hospital for a woman during the period of twelve weeks immediately following the termination of her pregnancy where a physician certifies, in accordance with regulations established by the Board, that the woman requires emergency medical care for the diagnosis or treatment of any injury, disability, or disease related to pregnancy; and

(3) inpatient services for a woman during pregnancy in any qualified obstetrical unit.

(b) For the purposes of this section, covered inpatient hospital services do not include the services of a private duty nurse or attendant.

COVERED DIAGNOSTIC SERVICES

SEC. 223. (a) Covered diagnostic services shall include diagnostic services performed by a qualified pathology laboratory—

(1) for a woman during pregnancy, and

(2) for a woman during the period of twelve weeks immediately following the termination of pregnancy,

if such woman is not an inpatient in a hospital or in a nursing home.

(b) Covered diagnostic services shall include diagnostic services performed by a qualified pathology laboratory to determine whether or not a woman is pregnant.

COVERED DRUGS AND BIOLOGICALS

SEC. 224. Covered drugs and biologicals shall include any drug or biological dispensed for use by a woman during pregnancy or during the period of twelve weeks immediately following the termination of her pregnancy, if such woman is not an inpatient in a hospital or nursing home, and if—

(1) such drug or biological is required, by section 503 (b) of the Federal Food, Drug, and Cosmetic Act, to be dispensed only upon prescription of a physician,

and such drug or biological is prescribed to be taken by such woman for a period of longer than four weeks, or

(2) such drug is insulin.

COVERED DEVICES, APPLIANCES, AND EQUIPMENT

SEC. 225. (a) Except as provided in subsection (b), covered devices, appliances, and equipment shall include the dispensing of such devices, appliances, and equipment as a physician may certify, in accordance with regulations established by the Board, as required for the treatment of a woman for any condition related to pregnancy during pregnancy or during the period of twelve weeks immediately following the termination of her pregnancy.

(b) The Board may, by regulation, exclude from covered devices, appliances, and equipment under subsection (a) the dispensing of such devices, appliances, and equipment as the Board determines to be ineffective, unreliable, or not cost-justified in the treatment of a condition related to pregnancy.

PART D—SPECIAL POPULATION BENEFITS

PURPOSE

SEC. 231. The purpose of this part is to furnish additional covered support services to individuals residing in inaccessible areas or who are otherwise unlikely to use the other services covered under this Act in order to promote the appropriate use of services under this Act by all individuals, regardless of race, income, health status, or location of residency.

SPECIAL POPULATION

SEC. 232. (a) The Board to the maximum extent feasible shall arrange for the furnishing of the covered support services, described in section 233, to individuals—

(1) who reside in a medically underserved area, as determined by the Board, or

(2) who, because of poverty, discrimination, or cultural barriers, are determined by the Board to suffer a higher risk of infant and maternal morbidity and mortality than other individuals.

(b) For the purposes of subsection (a), the term "medically underserved area" means an area with a shortage of persons furnishing professional services or inpatient services.

COVERED SUPPORT SERVICES

SEC. 233. (a) Covered support services shall include, with respect to an individual described in section 232 (a)—

(1) transportation of such individual (and, if such individual is a child, the parent or guardian of such child) to and from a person furnishing covered services to such individual under this Act;

(2) care of a dependent while such individual is being furnished covered services under this Act;

(3) social outreach assistance to inform such individual about and to assist such individual in receiving covered services furnished under this Act; and

(4) such similar services provided on behalf of such individual as the Board determines as necessary and appropriate to the purposes of this part,

if such services are provided by a person described in subsection (b).

(b) A support service described in subsection (a) is a covered service when furnished—

(1) under the supervision of a qualified institution, or

(2) by or under the supervision of a public or private nonprofit organization determined by the Board to have the organizational and financial capability to furnish such service on a dependable and fiscally responsible basis.

TITLE III—ADMINISTRATION AND METHOD OF PAYMENT OF BENEFITS

PART A—ADMINISTRATION AND GENERAL PROVISIONS

DEFINITIONS

SEC. 301. For the purposes of this title, the term—

(1) "carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under

group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization;

(2) "fee payment area" means an area designated by the Secretary, pursuant to section 1152(a) of the Social Security Act (42 U.S.C. 1320c–1), as appropriate with respect to the establishment of Professional Standards Review Organizations;

(3) "fee payment schedule" means a schedule, approved in accordance with section 312, of the amount of payments for the provision under this Act of various covered professional services;

(4) "covered institutional services" means—

(A) covered inpatient hospital services,

(B) covered nursing home services,

(C) covered home health care services,

(D) covered rehabilitative, social, and mental health services, and

(E) covered diagnostic services;

(5) "qualified institution" means—

(A) a qualified hospital,

(B) a qualified nursing home,

(C) a qualified home health agency,

(D) a facility described in section 216(a) (3), and

(E) a qualified pathology laboratory;

(6) "prospective rate schedule" means a schedule, approved in accordance with section 322, of the amount of payments for the provisions under this Act of various covered institutional services; and

(7) "person" includes a qualified institution.

DELEGATION OF SECRETARY'S AUTHOR[illegible]

SEC. 302. To the extent he deems it consistent with the purposes of this Act, the Secretary may delegate his authority for the administration of the system of payments for benefits provided for in this title to the Administrator of the Social Security Administration.

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 303. (a) In order to provide for the administration of the benefits under this Act with maximum efficiency and convenience for individuals eligible for benefits under this Act and for persons furnishing services to such individuals, the Secretary is authorized, after consultation with the Board, to enter into contracts with carriers to perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations)—

(1) (A) determine the amounts of payments required to be made under this Act;

(B) receive, disburse, and account for funds in making such payments;

(C) assist persons furnishing services under this Act in establishing and maintaining fiscal records necessary for purposes of this Act; and

(D) make such audits of the records of persons furnishing services as may be necessary to assure that proper payments are made under this Act;

(2) (A) determine compliance with the qualifications of section 202, and

(B) assist persons who furnish services for which payment may be made under this Act, in the development of procedures relating to utilization practices, make studies of the effectiveness of such procedures and methods for their improvement, assist in the application of safeguards against unnecessary utilization of services furnished by persons to individuals eligible for benefits under this Act, and provide procedures for and assist in arranging where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1861 (k) (2) of the Social Security Act) to make reviews of utilization;

(3) serve as a channel of communication of information relating to the administration of this Act; and

(4) otherwise assist, in such manner as the contract may provide, in discharging administrative duties necessary to carry out the purposes of this Act.

(b) (1) Contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

(c) Each such contract shall provide that—

(1) where the carrier has agreed to make payments under this Act—

(A) the carrier shall establish and maintain procedures by which a person furnishing services covered under this Act will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more—

(i) when requests for payment for such

services under this Act are denied or are not acted upon with reasonable promptness, or

(ii) when the amount of such payment is in controversy;

(B) the carrier shall use such standard forms and procedures for requests for payment as the Board may prescribe to minimize administrative work of physicians and others furnishing services covered under this Act;

(C) the Secretary shall advance funds to the carrier for the making of payments under this Act; and

(2) the carrier shall furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this Act; and

(3) the carrier shall maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under paragraph (2) and otherwise to carry out the purposes of this Act;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate.

(c) (1) Except as provided in paragraph (2), each contract shall be for a term of at least two years, and may be made automatically renewable from term to term in the absence of notice by either party of its intention not to renew the contract at the end of the current term.

(2) Each contract may be terminated—

(A) by the carrier at such time and upon such notice to the Secretary, to the Board, to the public, and to persons furnishing services under this Act, as the Secretary establishes by regulation, and

(B) by the Secretary at any time, after such reasonable notice to the carrier, the Board, the public, and to persons furnishing services under this Act and after such opportunity for a hearing to the carrier as the Secretary establishes by regulation, if the Secretary finds that—

(i) the carrier has failed substantially to carry out the contract, or

(ii) the carrier is carrying out all or some of the duties provided for in the contract in a manner inconsistent with the effective and efficient administration of this Act.

(d) (1) Any contract with a carrier under this section may require such carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(2) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

(3) No individual designated pursuant to a contract under this section as a disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by an individual designated pursuant to a contract under this section as a certifying officer.

(4) No such carrier shall be liable to the United States for any payments referred to in paragraph (2) or (3).

LIMITATION ON PAYMENTS

SEC. 304. (a) Payment for a covered service furnished under this Act may be made only—

(1) to the person furnishing such service,

(2) to the employer of such person, if such person has an agreement to turn over such payments to his employer, or

(3) to the facility in which such service was provided, if there is an agreement between such person and

facility under which the facility receives payments for such person's services.

(b) No payment may be made for covered institutional services furnished by a person prior to the Board's determination that such person is a qualified institution.

REQUIREMENT OF COPAYMENT FOR CERTAIN COVERED SERVICES

SEC. 305. (a) The Secretary shall pay 100 per centum of the full payment amount if—

(1) such covered service is other than one of the following:

(A) a home health service;

(B) a covered device, equipment, or appliance, described in section 218 or 225, or

(C) a covered professional service, other than preventive children's health services, furnished to a child; or

(2) such covered service is furnished under a fee schedule described in section 312(a)(2) (relating to capitation methods); or

(3) the individual to whom such covered service is furnished (or if the individual is a child, the parent or guardian of such child)—

(A) has an income below the poverty level, as determined by the Board, or

(B) is eligible in the State in which he resides for any benefits under title XIX of the Social Security Act (relating to medicaid).

(b) Except as provided in subsection (a), the Secretary shall pay 90 per centum of the full payment amount.

(c) For the purposes of this section, the term "full payment amount" means the amount specified in a schedule established pursuant to this title as representing full payment for the furnishing of any covered service.

SIMPLIFIED REQUEST FOR PAYMENT PROCEDURES

SEC. 306. The Secretary and the Board shall provide, to the extent consistent with the efficient administration of this Act, for the consolidation and standardization of simple forms and procedures which a physician, physician extender, or qualified institution must complete in order to request and receive payment for furnishing covered professional and institutional services under this Act.

PROHIBITION OF AND CONDITIONS FOR PAYMENTS

SEC. 307. (a) If the Board determines, after a hearing, held in accordance with subchapter II of chapter 5 of title 5, United States Code (Administrative Procedure Act), that a person furnishing covered services under this Act has—

(1) substantially or consistently violated the terms of an agreement required under the provisions of this title, or

(2) has substantially or consistently violated requirements for such person under this title,

the Board may prohibit, for such period, not to exceed one year, as it may deem appropriate, the making of any payments under this Act with respect to the furnishing of covered services by such person after the determination by the Board.

(b) If the Board determines, after a hearing held in accordance with subchapter II of chapter 5 of title 5, United States Code (Administrative Procedure Act), that a person furnishing covered services under this Act has violated an agreement containing the provisions of section 211 (c) (2), 311 (d) (1) (A), 311 (d) (2), 321 (b) (2), 321 (c) (2), 332 (c) (2), or 332 (d) (1), the Board may require, as a condition for such person having payments made under this Act for services furnished after the date of such determination, that such person provide an appropriate arrangement for the refunding of those fees and charges which were collected in violation of the applicable provisions of such sections.

PART B—PAYMENT FOR COVERED PROFESSIONAL SERVICES

GENERAL PROVISIONS

SEC. 311. (a) Payments shall be made by the Secretary for the furnishing of covered professional services in accordance with part A and this part.

(b) (1) In accordance with procedures established by the Secretary, after consultation with the Board, any person intending to request payment for its furnishing of covered professional services under this Act shall notify the Secretary of such intention at least thirty days prior to submittal of the first request for payment for such person.

(2) The Board shall make available, in such manner and form and at such times as the Board may consider appropriate, to the public the name, address, and telephone number of each person who has filed, pursuant to paragraph (1), notice of his intent to request payment for the furnishing of covered professional services under this Act.

(c) Any person furnishing covered professional services who intends to request payment under this Act for furnishing such services shall—

(1) display, in a manner prescribed by the Board, public notice of its participation in the program under this Act; and

(2) inform each patient (or if the patient is a child, the parent or guardian of such patient), prior to the furnishing of such services, the amount of any copayment the patient (or parent or guardian of such patient) must make for such services.

(d) (1) No payment shall be made pursuant to this Act to a person furnishing a covered professional service unless that person agrees—

(A) except as provided in section 313, to accept the amount specified in the appropriate fee payment schedule, established in accordance with section 312, as full payment for such services, and

(B) to provide such information, as the Secretary may require by regulation, to verify the service or services furnished.

(2) No payment shall be made pursuant to a fee payment schedule described in section 312 (a) (2) (relating to capitation payments) unless the person receiving payment pursuant to such schedule furnishes in an appropriate manner, determined by the Board, all services covered under such schedule, or has arranged, in an appropriate manner, determined by the Board, for the furnishing of all such services as it is not qualified to furnish.

(e) (1) Timely payment under this Act based on a fee payment schedule described in section 312 (a) (1) (relating to fee for service) shall be made in accordance with this Act after the furnishing of the service covered in such schedule.

(2) Timely payment under this Act based on a fee payment schedule described in section 312 (a) (2) (relating to capitation fees) shall be made in such a manner, to be determined by the Board, as to reflect the timing of normal furnishing of services to individuals receiving the care described in such section under this Act.

APPROVAL OF FEE PAYMENT SCHEDULES

SEC. 312. (a) In accordance with this section, the Board shall approve for each fee payment area a schedule of the amount of payments to be made under this Act for the furnishing of various covered professional services, and shall include—

(1) a fee payment schedule for the furnishing of individual services, and

(2) a fee payment schedule for the payment—

(A) of a single amount for the furnishing of prepaid pediatric care (as defined in subsection (f) (1)) for a period of not less than one year, as specified by the Board, and

(B) of a single amount for the furnishing of prepaid maternity care (as defined in subsection (f) (2)).

(b) For the purposes of this section, the Board shall designate for each fee payment area a fee payment board (hereinafter in this section referred to as the "fee payment board") which shall be—

(1) a nonprofit organization (or component thereof),

(2) composed of individuals furnishing covered professional services in such area, and

(3) open for membership to all individuals furnishing such professional services in such area.

(c) Each fee payment board shall submit to the Board a proposed fee payment schedule no later than 18 months after the date of enactment of this Act. Each such board may submit to the Board a proposed revision of such schedule once every year and at such other times as the Board, after consultation with the Secretary, may deem appropriate to the administration of this Act.

(d) (1) The Board shall approve a proposed fee payment schedule or a proposed revision thereof if it finds that such schedule or revision, except as provided in paragraph (2), reflects the prevailing fee for service or services in the fee payment area as of December 31, 1974, as adjusted according to such economic index or indices as the Board determines to be appropriate.

(2) A fee schedule described in subsection (a) (2) (relating to capitation payments) may provide for the payment of an amount, not to exceed by more than 10 per centum the amount otherwise payable under this subsection, in addition to the amount otherwise payable under this subsection.

(3) Where a fee payment schedule has not been proposed for a fee payment area, or where the Board does not

approve a proposed schedule, the Board shall approve as a fee payment schedule for such area—

(A) a schedule which reflects an approved schedule for an area similar in economic characteristics to the area involved, or

(B) where the Board determines that an area of similar economic characteristics does not exist, a schedule which, except as provided in paragraph (2) of this subsection, reflects the prevailing fee for service or services in the fee payment area as of December 31, 1974, as adjusted according to such economic index or indices as the Board determines to be appropriate.

(4) No later than one month before approval of a proposed schedule, and within one month after approval of a schedule, the Board shall publish notice of such schedule in the fee payment area covered by such schedule.

(e) Persons adversely affected by the Board's approval or disapproval of a fee payment schedule under this section may seek review of such approval or disapproval under the procedures provided in subchapter II of chapter 5 of title 5, United States Code (Administrative Procedure Act).

(f) As used in this section, the term—

(1) "prepaid pediatric care" means covered professional services under section 211 including—

(A) preventive children's health services, and

(B) such other health services as may be determined by the Board as appropriate for the diagnosis and treatment of common pediatric conditions; and

(2) "prepaid maternity care" means such covered professional services under section 221 as the Board determines are ordinary and appropriate in a normal maternity case.

DEMONSTRATION METHODS OF PAYMENT

SEC. 313. (a) In lieu of payment pursuant to section 312, a fee payment board may propose and the Board may approve, on an experimental or demonstration basis for a period not to exceed two years, a method of payment for covered professional services furnished under this Act, if the Board determines that the total amount of payments under such method will not exceed the total amount of payments which would otherwise be made under the applicable fee payment schedule.

(b) The Board shall report to Congress on the results of any experiments or demonstrations under subsection (a), and include in such report such recommendations for changes in the methods of payment under this Act as the Board determines are appropriate.

PART C—PAYMENT FOR COVERED INSTITUTIONAL SERVICES

GENERAL PROVISIONS

SEC. 321. (a) Payments shall be made on a timely basis and in accordance with part A and this part by the Secretary for covered institutional services.

(b) No payment shall be made under this Act to a qualified institution furnishing covered institutional services unless such institution—

(1) has submitted and has had approved by the Board a prospective rate schedule, in accordance with section 322;

(2) agrees to accept the amount specified in such schedule as full payment for such services; and

(3) agrees to provide such information, as the Secretary may require by regulation, to verify its qualifications as a qualified institution and to verify the services furnished under this Act.

(c) Any qualified institution which has had a prospective rate schedule, for its furnishing of covered institutional services, approved pursuant to section 322, and which intends to request payment under this Act for furnishing such services shall—

(1) display, in a manner prescribed by the Board, public notice of its participation in the program under this Act, and

(2) inform each patient (or if patient is a child, the parent or guardian of such patient), prior to the furnishing of such services, the amount of any copayment the patient (or parent or guardian of such patient) must make for such services.

APPROVAL OF PROSPECTIVE RATE SCHEDULES

SEC. 322. (a) (1) The Board, after consultation with the Secretary, qualified institutions, carriers, and other interested parties and organizations, shall establish one or more methods (hereinafter in this section referred to as "methods"), which satisfy the criteria of subsection (b), for the establishment of a prospective rate schedule for the payment of qualified institutions furnishing covered institutional services under this Act.

(2) The Board may modify or eliminate a method or methods established under paragraph (1) where it determines, after consultation with qualified institutions which have submitted to the Board a proposed prospective rate

schedule based on such method, and with the Secretary, carriers, and other interested parties and organizations, that—

(A) such method or methods are inconsistent with the provisions of subsection (b), or

(B) are inconsistent with the efficient administration or purposes of this Act.

(3) Any modification or elimination of a method or methods pursuant to paragraph (2) shall take effect, with respect to a qualified institution which has submitted to the Board a proposed prospective rate schedule based on such method, no earlier than six months after the Board has notified such institution of such modification or elimination of such method or methods.

(b) Any method established by the Board pursuant to subsection (a) for payment of qualified institutions for furnishing covered institutional services shall provide—

(1) for the establishment of rates of payment for such services in advance of the time when such services are furnished and without regard to costs actually incurred in furnishing such services;

(2) for the revision of such rates no more frequently than once every year, unless the Board determines that more frequent adjustments are appropriate due to significant unforeseeable events, including—

(A) natural disasters and catastrophes,

(B) epidemics,

(C) major economic dislocations not under the control of the institution furnishing such services, and

(D) significant changes in patient mix not under the control of the institution furnishing such services;

(3) financial incentives for improved efficiency in the furnishing of such services by sharing savings with qualified institutions that perform at lower than anticipated costs;

(4) incentives for improved quality in the furnishing of covered services;

(5) for a reasonable return on investment based on a rate of return on investment of comparable risk and computed at the time such prospective rate schedule is established; and

(6) for payment of such portion of the operation and administration (including the financing of capital improvements), of such qualified institution's program as is necessary for the furnishing of such services, and, if subject to review by a health systems agency under section 1513 (e) (1) (A) of the Public Health Services Act, as has been approved by such agency.

(c) Each person who intends to request payment for the furnishing of covered institutional services pursuant to this Act—

(1) shall submit to the Board a proposed prospective rate schedule for the furnishing of such services based on a method established by the Board pursuant to this section, and

(2) may submit to the Board, after such schedule has become effective, a proposed revision of such schedule—

(A) once every year,

(B) when the Board modifies or eliminates a method, pursuant to subsection (a) (2), upon which such schedule has been based, and

(C) at such other times as the Board, after consultation with the Secretary, determines is consistent with subsection (b) (2) and is appropriate for the administration of this Act.

(d) (1) Unless the Board, no later than sixty days after the date of the submittal of a proposed prospective rate schedule or a proposed revision thereof, finds that such schedule or revision is inconsistent with a method established by the Board, such schedule or revision thereof shall become effective sixty days after the date of such submittal.

(2) No later than ten days after the date a proposed

rate schedule or a revision thereof is submitted to the Board, the person submitting the proposal shall publish such proposed schedule or revision in such region affected by the proposal and in such a manner as the Board may determine is appropriate to carry out the purposes of this Act.

(c) Persons adversely affected by the Board's approval or disapproval of a prospective rate schedule or revision thereof under this section may seek review of such approval or disapproval under the procedures provided in subchapter II of chapter 5 of title 5, United States Code (Administrative Procedure Act).

PART D—PAYMENT FOR DRUGS, DEVICES, AND SPECIAL POPULATION BENEFITS

DEFINITIONS

SEC. 331. As used in this part, the term—

(1) "dispenser" means any person who has notified the Secretary, pursuant to section 332(b)(1), of his intention to request payment under this Act for the dispensing of covered drugs and devices; and

(2) "covered drugs and devices" means covered drugs and biologicals, and covered devices, appliances, and equipment.

PAYMENT FOR COVERED DRUGS AND DEVICES

SEC. 332. (a) Payments shall be made by the Secretary for the dispensing of covered drugs and devices in accordance with part A and this part.

(b) (1) In accordance with procedures established by the Secretary, after consultation with the Board, any person intending to request payment for its dispensing of covered drugs and devices under this Act shall notify the Secretary of such intention at least thirty days prior to submittal of the first request for payment for such person.

(2) The Board shall make available, in such manner and at such times as the Board may consider appropriate, to the public the name, address, and telephone number of each dispenser.

(c) Each dispenser shall—

(1) display, in a manner prescribed by the Board, public notice of its participation in the program under this Act; and

(2) inform each patient (or if the patient is a child, the parent or guardian of such patient), prior to the dispensing of such drugs or devices, the amount of any copayment the patient (or the parent or guardian of such patient) must make for such drugs or devices.

(d) No payment shall be made pursuant to this Act to a dispenser unless that person agrees—

(1) to accept the amount specified in accordance with subsection (e), as full payment for the dispensing of such drug or device, and

(2) to provide such information, as the Secretary

may require by regulation, to verify the drug or device dispensed.

(e) The amount of payment made under this Act for the dispensing of a covered drug or device shall be the sum of—

(1) the wholesale cost of such drug or device, as determined under the schedule adopted pursuant to subsection (f), and

(2) a fee for the dispensing of such drug or device (hereinafter in this section referred to as a "dispensing fee"), as determined under the schedule adopted pursuant to subsection (g).

(f) (1) The Board shall determine and publish, no less often than annually, a schedule of the wholesale cost of covered drugs and devices commonly dispensed under this Act, and shall establish by regulation procedures for determination of the wholesale cost of covered drugs and devices not commonly dispensed under this Act.

(2) The Board may provide in such schedule for variations in the wholesale cost to reflect differences in costs to a dispenser as a result of differences in size of the dispenser and differences in the regional location of the dispenser.

(g) (1) A dispenser requesting payment under this part shall submit to the Board, in a form prescribed by the Board, a proposed schedule of dispensing fees.

(2) Such schedule may be revised once every year and

at such other times as the Board, after consultation with the Secretary, determines is consistent with the administration of this Act.

(3) The Board shall approve such proposed schedule or proposed revision thereof unless, no later than sixty days after the submittal of such proposed schedule or of a proposed revision thereof, it finds that the dispensing fees in such schedule or revision are not in excess of a percentage of the schedule of wholesale costs (determined pursuant to subsection (f)) sufficient to compensate the dispenser for the reasonable costs of dispensing such drug or device.

(4) No dispensing fee shall be approved under this section if the dispenser is a physician, unless the Board determines that there is no dispenser (other than a physician) in the community in which such physician requests to dispense covered drugs or devices.

PAYMENT FOR SPECIAL POPULATION BENEFITS

SEC. 333. (a) Payments shall be made by the Secretary for the furnishing of covered support services in accordance with part A and this section.

(b) The Board shall provide for grants to persons described in section 233 (b) for the furnishing of covered support services in such reasonable amounts as the Board determines are necessary and appropriate for the efficient furnishing of such services.

TITLE IV—FINANCING THE MATERNAL AND CHILD HEALTH PROGRAM

PART A—FUNDS FOR SUPPORT OF THE MATERNAL AND CHILD HEALTH PROGRAM

AUTHORIZATION OF APPROPRIATIONS

SEC. 401. (a) In order to assure prompt payment for the administrative and other expenses incurred during the early months of the program established by this Act, and in order to provide a contingency reserve, there is authorized to be appropriated, out of any moneys in the Treasury not otherwise appropriated, to remain available through a period of three years beginning with the date of enactment of this Act the amount of $100,000,000 for repayable advances (without interest) to the Trust Fund created by section 411.

(b) There are hereby authorized to be appropriated to the Trust Fund created by section 411 in each fiscal year such funds, in addition to funds deposited in such fund pursuant to section 412, as may be required by the Secretary to carry out the purposes of this Act.

PAYROLL AND SELF-EMPLOYMENT TAXES

SEC. 402. (a) Section 3101 of the Internal Revenue Code of 1954 (relating to social security and medicare taxes on employees) is amended by adding at the end thereof the following new subsection:

"(c) MATERNAL AND CHILD HEALTH CARE.—In addition to the taxes imposed by the preceding subsections, there is hereby imposed on the income of every individual a tax equal to 0.10 percent of the wages (as defined in section 3121 (a)) received by him with respect to employment (as defined in section 3121 (r)).".

(b) Section 3111 of such Code (relating to social security and medicare taxes on employers) is amended by adding at the end thereof the following new subsection:

"(c) MATERNAL AND CHILD HEALTH CARE.—In addition to the taxes imposed by the preceding subsections, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to 0.10 percent of the wages (as defined in section 3121 (a)) paid by him with respect to employment (as defined in section 3121 (r)).".

(c) Section 3121 of such Code (containing definitions applicable to social security payroll taxes) is amended by adding at the end thereof the following new subsection:

"(r) EMPLOYMENT FOR PURPOSES OF MATERNAL AND CHILD HEALTH CARE TAX.—For the purposes of sections 3101 (c) and 3111 (c), the term 'employment' has the meaning set forth in subsection (b) of this section except that—

"(1) the exclusions contained in the following paragraphs of subsection (b) shall not be applied—

"(A) paragraph (1) (relating to foreign agricultural workers);

"(B) paragraphs (5) and (6) (relating to employment by the United States or its instrumentalities) other than paragraph (6) (C) (iii) through (v) (relating to certain minor employments);

"(C) paragraph (7) (relating to employment by States and their political subdivisions and instrumentalities) other than paragraph (7) (C) (i) through (iv) (relating to certain minor employments by the District of Columbia);

"(D) paragraph (8) (relating to employment by charitable and similar organizations);

"(E) paragraph (9) (relating to employment covered by the railroad retirement system); and

"(F) paragraph (17) (relating to employment by subversive organizations); and

"(2) subsection (m) of this section (including services by members of the uniformed services in the term 'employment') shall not be applied.".

(d) Section 1401 of such Code (imposing social security and medicare taxes on self-employed individuals) is amended by adding at the end thereof the following new subsection:

"(c) MATERNAL AND CHILD HEALTH CARE.—In addition to the taxes imposed by the preceding subsections, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to 0.10 percent of the amount of the self-employment income for such taxable year.".

TECHNICAL AND CONFORMING AMENDMENTS

SEC. 403. Section 218 of the Social Security Act (42 U.S.C. 418) (relating to agreements for the coverage of services performed in the employ of States and their political subdivisions and instrumentalities) is amended—

(1) by inserting in subsection (e) (1) (A) "subsections (a) and (b) of" immediately before "sections 3101 and 3111";

(2) by inserting in subsection (e) (2) (B) "subsections (a) and (b) of" immediately before "section 3111"; and

(3) by adding at the end of subsection (e) the following new paragraph:

"(3) Notwithstanding the provisions of any agreement entered into under this section, no State shall be under any obligation to pay to the Secretary of the Treasury, with respect to service covered under the agreement and performed on or after the effective date of section 402 (d) of the Maternal and Child Health Care Act, amounts equivalent to the taxes which would be imposed by sections 3101 (c) and 3111 (c) of the Internal Revenue Code of 1954 if such service constituted employment as defined in section 3121 (b) or section 3121 (r) of such Code.”.

PART B—MATERNAL AND CHILD HEALTH TRUST FUND

CREATION OF THE TRUST FUND

SEC. 411. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the Maternal and Child Health Trust Fund (hereinafter in this part referred to as the “Trust Fund”).

(b) The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 412 (c), and such amounts as may be appropriated to or deposited in such fund as provided in this part.

FUNDING OF TRUST FUND

SEC. 412. (a) There are hereby appropriated to the Trust Fund for the fiscal year ending September 30, 1976, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1) the taxes imposed by section 3101 (c) and 3111 (c) of the Internal Revenue Code of 1954 with respect to wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of such Code on and after the effective date of section 402 (a) of the Maternal and Child Health Care Act, as determined by the Secretary of the Treasury by applying the applicable

rates of tax under such sections to such wages, which wages shall be certified by the Secretary of Health, Education, and Welfare in accordance with such reports; and

(2) the taxes imposed by section 1401 (c) of the Internal Revenue Code of 1954 with respect to self-employment income reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code on and after the effective date of section 402 (d) of the Maternal and Child Health Care Act, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such section to such self-employment income, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of records of self-employment established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns.

(b) The amounts appropriated by subsection (a) shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in subsection (a), paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such subsection.

(c) The Managing Trustee of the Trust Fund is authorized to accept on behalf of the United States, and deposit into the Trust Fund, money, gifts, and bequests made unconditionally to the Trust Fund or to the Department of Health, Education, and Welfare, or any part or officer thereof, for the benefit of such Fund or any activity financed through such Fund.

MANAGEMENT OF TRUST FUND

SEC. 413. (a) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this part referred to as the "Board of Trustees") composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, all ex officio.

(b) The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (in this part being referred to as the "Managing Trustee"). The Commissioner of the Social Security shall serve as the Secretary of the Board of Trustees.

(c) The Board of Trustees shall meet not less frequently than once each calendar year.

(d) It shall be the duty of the Board of Trustees to—

(1) hold the Trust Fund;

(2) submit to the Congress not later than the first day of April of each year a report, to be printed as a House document of the session of the Congress to which the report is made, on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next two fiscal years, which report shall include—

(A) a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year;

(B) an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next two fiscal years; and

(C) a statement of the actuarial status of the Trust Fund; and

(3) report immediately to the Congress whenever the Board of Trustees is of the opinion that the amount of the Trust Fund is unduly small; and

(4) review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

INVESTMENT OF FUNDS FOR THE TRUST FUND

SEC. 414. (a) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals.

(b) (1) Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States.

(2) For such purpose such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

(c) (1) The purposes for which obligations of the United States may be issued under the Second Liberty Bond Act are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund.

(2) Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of four years from the end of such calendar month; except that where such

average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield.

(d) The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

(e) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(f) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

ADJUSTMENT OF TRUST FUND FOR OVERPAYMENTS AND UNDERPAYMENTS

SEC. 415. (a) (1) The Managing Trustee shall pay from time to time from the Trust Fund into the Treasury the amount estimated by him as taxes imposed under section 3101 (c) of the Internal Revenue Code of 1954 which are subject to refund under section 6413 (c) of such Code with respect to wages paid on or after January 1 of the year following the date of enactment of this Act.

(2) Such taxes shall be determined on the basis of the records of wages established and maintained by the Secretary in accordance with the wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, and the Secretary shall furnish the Managing Trustee such information as may be required by the Managing Trustee for such purpose.

(3) The payments by the Managing Trustee shall be covered into the Treasury as repayments to the account for refunding internal revenue collections.

(b) Repayments made under subsection (a) shall not be available for expenditures but shall be carried to the surplus fund of the Treasury. If it subsequently appears that the estimates under such paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Managing Trustee in future payments.

PAYMENT OF SERVICES AND ADMINISTRATIVE EXPENSES

SEC. 416. The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary certifies are necessary to make the payments provided for by title III of this Act and to make payments for administrative and research expenses incurred under this Act.

TITLE V—PENALTIES, EFFECTIVE DATES, AND TECHNICAL AMENDMENTS

PENALTIES

SEC. 501. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact—

(A) in any request for payment under this Act,

(B) for use in determining eligibility for any benefit under this Act,

(C) for use in determining the qualifications of an institution, under section 202, to have payments made under this Act for such institution's furnishing of services, or

(2) knowingly and with fraudulent intent conceals or fails to disclose a material fact—

(A) in any request for payment under this Act,

(B) for use in determining eligibility for any benefit under this Act,

(C) for use in determining the qualifications of an institution, under section 202, in order to have payments made under this Act for such institution's furnishing of services; or

(3) having made application to, and received, any such benefit or payment for the use and benefit of another, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

(b) Whoever furnishes or dispenses a covered service to an individual for which payment may be made under this Act and who solicits, offers, or receives any—

(1) kickback or bribe in connection with the furnishing or dispensing of such service or the making or receipt of such payment, or

(2) rebate of any fee or charge for referring any such individual to another person for the furnishing or dispensing of such service,

shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

EFFECTIVE DATES

SEC. 502. (a) Except as provided in subsections (b), (c), (d), and (e), the provisions of this Act shall take effect on the date of enactment of this Act.

(b) Sections 402 (a), 402 (b), 402 (d), and 412 (a) (relating to collection of maternal and child health care taxes) shall take effect on January 1 of the year following the date of enactment of this Act.

(c) Part B of title II (relating to children's benefits) shall take effect on the following dates for children of the following ages on those dates—

(1) two years after the date of enactment of this Act for children below the age of three years;

(2) four years after the date of enactment of this Act for children below the age of seven years;

(3) five years after the date of enactment of this Act for children below the age of thirteen years; and

(4) six years after the date of enactment of this Act for all children eligible under this Act.

(d) Part C of title II (relating to maternity benefits) shall take effect two years after the date of enactment of this Act.

(e) Part D of title II (relating to special population benefits) shall take effect on the effective date, specified in subsection (c) or (d) of this section, for the furnishing of covered services to which covered support services under such part are related.

CONFORMING AMENDMENTS

SEC. 503. (a) Title V of the Social Security Act is amended by adding at the end thereof the following new section:

"PAYMENTS FOR SERVICES UNDER MATERNAL AND CHILD HEALTH CARE ACT

"SEC. 517. No payment may be made under this title for the furnishing of services which would be eligible for payment as a covered service under the Maternal and Child Health Care Act.".

(b) Section 1862 of the Social Security Act (42 U.S.C. 1395y) is amended by adding immediately after subsection (d) the following new subsection:

"(e) No payment may be made under this title for the furnishing of services which would be eligible for payment as a covered service under the Maternal and Child Health Care Act.".

(c) Title XIX of the Social Security Act is amended by adding at the end thereof the following new section:

"PAYMENTS FOR SERVICES UNDER THE MATERNAL AND CHILD HEALTH CARE ACT

"SEC. 1911. No payment may be made under this title for the furnishing of services which would be eligible for payment as a covered service under the Maternal and Child Health Care Act.".

94TH CONGRESS
2D SESSION

H. R. 14497

IN THE HOUSE OF REPRESENTATIVES

JUNE 22, 1976

Mr. SCHEUER introduced the following bill; which was referred jointly to the Committees on Interstate and Foreign Commerce and Ways and Means

---

A BILL

To establish a national health insurance system for maternal and child health care.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act with the table of contents may be cited as the "National Health Insurance for Mothers and Children Act".

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FINDINGS AND DECLARATION OF PURPOSE

SEC. 2. (a) The Congress finds and declares that—

(1) the mothers and children of this Nation are the foundation of its future strength, productivity, and prosperity;

(2) adequate health care for mothers and children is essential to safeguard this precious resource; and

(3) adequate medical care for pregnant women and children has the greatest potential for improving the health status of the general population.

(b) The purpose of this Act is—

(1) to establish a system of national health insur-

ance and health care benefits for children and pregnant women residing in the United States;

(2) to increase the access of such individuals to health care, to enhance its quality, and to emphasize the prevention of disease as well as the treatment of illness; and

(3) to improve the efficiency and the use of resources and to restrain the increasing costs of maternal and child health care, while providing fair and reasonable compensation to those who furnish it.

FREE CHOICE BY PATIENT AND PRACTITIONER

SEC. 3. The administration of this Act shall not interfere with the freedom of any physician to choose to whom health care will be provided by the physician or any patient to choose the physician from whom they will receive health care.

OBSERVANCE OF RELIGIOUS BELIEFS

SEC. 4. Nothing in this Act shall be construed to authorize the Secretary or the Board (or any of their agents or employees) to compel any person to undergo any medical screening, examination, diagnosis, or treatment, or to accept any other health care services provided under this Act for any purpose; and the participation by any individual in health care provided under this Act shall be wholly voluntary.

TITLE I—GENERAL PROVISIONS AND ADMINISTRATION

PART A—GENERAL PROVISIONS

DEFINITIONS

SEC. 101. For the purposes of this Act, the term—

(1) "Secretary" means the Secretary of Health, Education, and Welfare;

(2) "Board" means the Maternal and Child Health Board established by section 111;

(3) "child" means an individual from the time of birth to the age of eighteen years;

(4) "woman" means a female during pregnancy and during the twelve weeks immediately following her pregnancy;

(5) "Council" means the National Maternal and Child Health Council established by section 121;

(6) "covered service" means a health care service or item described in title II for which payment may be made in accordance with title III of this Act; and

(7) "alien lawfully admitted for permanent residence" includes an alien permanently residing in the United States under color of law and an alien who is lawfully present in the United States as a result of the application of section 203 (a) (7) or section 212 (d) (5) of the Immigration and Nationality Act; and

(8) "State" includes the District of Columbia, the Commonwealth of Puerto Rico, and the territory of the Virgin Islands, Guam, and American Samoa.

ELIGIBILITY FOR BENEFITS

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SEC. 102. (a) Every individual—

(1) who is a citizen of the United States or an alien lawfully admitted for permanent residence, and

(2) who is a child or who is pregnant,

shall be eligible to have payment made for health care services received by such individual in accordance with the provisions of this Act.

(b) Any female individual who is described in subsection (a) (1) shall be eligible to have payment for health care services received by such individual in order to determine whether or not such individual is pregnant, in accordance with the provisions of this Act.

PART B—ADMINISTRATION

ESTABLISHMENT OF THE MATERNAL AND CHLD HEALTH BOARD

SEC. 111. (a) There is hereby established in the Department a Maternal and Child Health Board to be composed of five members to be appointed by the President, by and with the consent of the Senate. During his term of membership on the Board, no member shall engage in any other business, vocation, or employment. Not more than two members of the Board shall be members of the same political party.

(b) Each member of the Board shall hold office for a term of five years except that—

(1) a member appointed to fill a vacancy occurring during the term for which his predecessor was appointed shall be appointed for the remainder of that term, and

(2) the terms of office of the members first appointed shall expire, as designated by the President at the time of their appointment, at the end of one, three, and five years, respectively, after the date of enactment of this Act.

A member who has served for two consecutive five-year terms shall not be eligible for reappointment until two years after he has ceased to serve.

(c) The President shall designate one of the members of the Board as Chairman of the Board.

DUTIES OF THE BOARD

SEC. 112. (a) In addition to the specific duties given the Board under this Act, the Board shall—

(1) except as specifically provided under this Act, have the duty of administering titles II and III of this Act (relating to nature and scope of benefits and administration and method of payment of benefits under this Act), and

(2) have the general duty of continuously study-

ing the operation of this Act and of the most effective methods of providing comprehensive personal health services to mothers and children in the United States, and of making recommendations on legislation and matters of administrative policy with respect thereto.

(b) The Board shall make an annual report to the Congress on the administration of the functions with which it is charged. The report shall include, for periods prior to the effective date of health benefits, an evaluation by the Board of the progress in preparing for the initiation of benefits under this Act, and for periods thereafter, an evaluation of the operation of the Act, of the adequacy and quality of services furnished under it, of the adequacy of compensation to the providers of services, of the costs of the services and the effectiveness of measures to control such costs, of its coordination with the National Council on Health Planning and Development established under the Public Health Service Act and of detailed comments respecting disapproval of any Maternal and Child Health Council recommendations.

(c) The Secretary shall make available to the Board all information available to him from sources within the Department or from other sources, pertaining to the functions and duties of the Board.

EXECUTIVE DIRECTOR, EMPLOYMENT OF STAFF, AND DELEGATION OF AUTHORITY

SEC. 113. (a) There is hereby established the position of Executive Director of the Maternal and Child Health Board. The Executive Director shall be appointed by the Board with the approval of the Secretary and shall perform such duties in the administration of this Act as the Board assigns.

(b) (1) The Board is authorized to employ such individuals, in accordance with the provisions of title 5, United States Code, as may be necessary to carry out its functions under this Act.

(2) To the extent it deems it consistent with the purposes of this Act and its duties under this Act, the Board may employ such hearing examiners as it determines to be necessary to promote the resolution of disputes over—

(1) an individual's eligibility for covered benefits under section 102;

(2) the qualifications of institutions, under section 202;

(3) the appropriateness of a fee payment schedule, prospective rate schedule, wholesale cost schedule, of dispensing fee schedule established under title III;

(4) the reasonableness of payments for special population benefits, under section 333; or

(5) violation of an agreement required under section 307 or the requirements of title III under section 307.

(c) The Board is authorized to delegate to the Executive Director, to any other officer or employee of the Board, or, with the approval of the Secretary, to any other officer or employee of the Department, any of its functions or duties under this Act, other than the issuance of regulations.

REGULATIONS OF AND SUBPOENAS BY THE BOARD

SEC. 114. (a) The Board shall prescribe such regulations as may be necessary to carry out its duties under this Act.

(b) (1) For the purpose of any hearing, investigation, or other proceeding authorized under this Act, the Board may issue subpoenas requiring persons any place in the United States to attend and testify as witnesses at the designated place of such hearing, investigation, or other proceeding, and to produce any evidence that relates to any matter under investigation or in question before the Board. Subpoenas of the Board shall be served by anyone authorized by it by delivering a copy thereof to the person named therein, or by mailing a copy by registered mail or by certified mail addressed to such individual at his last dwelling place or principal place of business. A verified return by the individual so serving the subpoena setting forth the manner of service, or, in the case of service by registered mail or by certified mail, the return post office receipt therefor signed by the person so served, shall be proof of service. Witnesses so subpoenaed shall be paid the same fees and mileage as are paid witnesses in the district courts of the United States.

(2) In case of contumacy by, or refusal to obey a subpoena duly served upon, any person, any district court of the United States for the judicial district in which such person charged with contumacy or refusal to obey is found or resides or transacts business, upon application by the Board, shall have jurisdiction to issue an order requiring such person to appear and give testimony, or to appear and produce evidence, or both; any failure to obey such order of the court may be punished by such court as contempt thereof.

FUNDS FOR THE EVALUATION OF THE MATERNAL AND CHILD HEALTH CARE PROGRAM

SEC. 115. (a) The Secretary shall allocate to the Office of Research and Statistics of the Social Security Administration an amount equal to one-tenth of 1 per centum of the total amount of payments made under this Act for the purpose of evaluating the operation of this Act and the impact of such operation on existing private health insurance programs.

(b) Not less often than annually, such Office shall report to the Secretary, to the Board, and to the Congress on the operation of this Act and shall include in such report any recommendations for changes in the operation of this Act.

PART C—ADVISORY COUNCIL

ESTABLISHMENT OF NATIONAL MATERNAL AND CHILD HEALTH COUNCIL

SEC. 121. (a) There is hereby established a National Maternal and Child Health Council, which shall consist of the Chairman of the Board, who shall serve as Chairman of the Council, and ten members, not otherwise in the employ of the United States, appointed by the Secretary, on recommendation of the Board, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, as follows:

(1) not less than six individuals who—

(A) are not engaged in and have no financial interest in the furnishing of any health services,

(B) as a result of their training, experience or attainments are exceptionally well qualified as representatives of consumers of maternal and child health care services,

(C) as a result of their training, experience or attainments are exceptionally well qualified and familiar with the health care needs of mothers and children, and

(D) as a result of their training, experience or attainments are exceptionally well qualified and experienced in dealing with problems associated with the obtaining of maternal and child health care services; and

(2) not more than four individuals who—

(A) as a result of their training, experience or attainments are exceptionally well qualified in fields realted to medical, hospital, or other health activities, or

(B) as a result of their training, experience or attainments are exceptionally well qualified and representative of organizations or associations of professional health personnel.

(b) Each member of the Council shall serve for a term of five years, except that—

(1) any member appointed to fill a vacancy occurring during the term for which his predecessor was appointed shall be appointed for the remainder of that term; and

(2) the terms of members first appointed shall expire, as designated by the Secretary at the time of their

appointment, two at the end of the first year, two at the end of the second year, two at the end of the third year, two at the end of the fourth year, and two at the end of the fifth year after the date of enactment of this Act.

DUTIES OF COUNCIL

SEC. 122. (a) The Council shall—

(1) advise the Board on matters of general policy in the administration of this Act, in the formulations of regulations, and in the performance of the Board's functions and duties,

(2) study the operation of this Act and the use of maternal and child health care services under it, and

(3) recommend to the Board such changes in the administration of the provisions of the Act as it deems desirable.

(b) The Council shall make an annual report to the Board on the performance of its functions, including any recommendations it may have with respect thereto, and shall promptly transmit such report to Congress.

(c) The Council shall meet as frequently as the Board deems necessary, but not less than four times each year. Upon request of six or more members, it is the duty of the Chairman to call a meeting of the Council.

APPOINTMENT OF STAFF AND COMPENSATION

SEC. 123. (a) The Council is authorized to appoint such professional or technical consultants as may be necessary to carry out its duties.

(b) The Board shall provide such secretarial, clerical, and other assistance as the Council may require to carry out its duties under this Act.

(c) Members of the Council and technical or professional consultants, while serving or traveling on business of the Council, shall receive compensation at rates fixed by the Board, but not in excess of the equivalent of the daily rate paid under GS–18 of the general schedule under section 5332 of title 5, United States Code; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703(b) of title 5, United States Code, for persons in Government service employed intermittently.

TITLE II—NATURE AND SCOPE OF BENEFITS

PART A—DEFINITIONS AND QUALIFICATIONS OF INSTITUTIONS

DEFINITIONS, GENERAL TERMS AND SERVICES

SEC. 201. For the purpose of this title and title III, the term—

(1) "physician" means a doctor of medicine, osteopathy, dentistry, optometry, or podiatry who is legally authorized to practice his or her profession in the State in which he or she performs such functions;

(2) "physician extender" means a physician assistant, dental auxiliary, nurse practitioner, or nurse midwife under the supervision of a physician whether or not performed in the office of such physician or at a place at which he or she is present if the individual may legally perform the services in the State in which the services are performed;

(3) "professional services" means medical services provided by a physician or physician extender and includes materials and supplies commonly furnished, without separate charge, by a physician or physician extender as an incident to the provision of such services;

(4) "preventive children's health services" means professional services the frequency and content of which are determined by the Board, after consultation with the Council, to be ordinarily necessary to maintain the health of a child and to prevent common illnesses, and may include medical and dental evaluations, immunizations, screening for vision and hearing defects, and appropriate health education;

(5) "inpatient services" means—

(A) bed and board;

(B) such nursing, medical, rehabilitative, and other services as are ordinarily furnished by a qualified hospital for the care and treatment of inpatients;

(C) such mental health services, including psychiatric and psychological services, only as are authorized pursuant to regulations established by the Board for the health of the child;

(D) drugs, biologicals, blood and blood products, supplies, appliances, and equipment for use in a hospital for the care and treatment of inpatients; and

(E) such other diagnostic and therapeutic items and services ordinarily furnished by a qualified hospital, or by others by arrangement with such hospital, to inpatients.

(6) "home health services" means nursing services and homemaking services, as defined by the Board;

(7) "diagnostic services" means tests for the purpose of providing information for the diagnosis, prevention, or treatment of any injury, disability, or disease or for the assessment of the health of an individual;

(8) "emergency medical care" means medical care

for patients with a severe, life-threatening, or potentially disabling condition which requires medical intervention within minutes or hours after the onset of such condition; and

(9) "support services" means services described in section 233.

STANDARDS FOR QUALIFIED INSTITUTIONS

SEC. 202. For the purposes of this title and title III, the term—

(1) "qualified hospital" means a hospital which, as determined in accordance with section 203—

(A) provides diagnostic and therapeutic services to patients for a variety of medical conditions;

(B) maintains clinical records on all its patients;

(C) has published bylaws in effect with respect to the qualifications, rights, and responsibilities of its staff of physicians;

(D) shall not discriminate on any arbitrary ground unrelated to professional qualifications in the granting or maintaining of medical staff privileges;

(E) requires that every patient must be under the direct and personal care of a single physician;

(F) provides twenty-four-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;

(G) has a pharmaceutical and drug therapeutics committee which establishes policies for the selection, acquisition, and use of drugs;

(H) has in effect a hospital utilization review plan which meets the requirements of title XVIII of the Social Security Act;

(I) meets all applicable requirements of the laws of the State and of the locality in which it is situated; and

(J) meets such other requirements as the Board finds necessary in the interest of the health and safety of the individuals who are furnished services in such institution.

(2) "qualified pediatric unit" means a unit in a qualified hospital which, as determined in accordance with section 203--

(A) is a separate unit in the hospital for the exclusive use of children;

(B) contains at least twelve beds;

(C) has an annual occupancy rate of at least 70 per centum;

(D) has no restrictions on visiting hours for parents and guardians except as medically required; and

(E) has a reasonable and adequate arrangement for overnight accommodation of the parent, guardian, or adult friend of a patient under the age of seven years.

(3) "qualified obstetrical unit" means a unit in a qualified hospital which, as determined in accordance within section 203—

(A) is a separate unit in the hospital for the exclusive use of obstetrical patients;

(B) has an average of at least—

(i) 500 deliveries annually if located in a rural area (as defined by the Board), or

(ii) 1,500 deliveries annually if not located in a rural area.

The Board may waive the required number of deliveries specified in subparagraph (B) (i) if it finds it in the best interest of the medical care of pregnant women in the area.

(4) "qualified nursing home" means an institution which, as determined in accordance with section 203—

(A) provides skilled nursing and related services to inpatients who are not being treated primarily for mental illness;

(B) has written policies, established and periodically reviewed by a group including at least one physician and at least one registered nurse, governing its furnishing of health services, including the dispensing and administering of drugs;

(C) has a full-time physician or full-time registered nurse supervising its furnishing of medical services;

(D) requires that every patient must be under the direct and personal care of a single physician;

(E) has a physician available to furnish emergency medical care;

(F) maintains clinical records on all its patients;

(G) has in effect a utilization review plan which meets the requirements of title XVIII of the Social Security Act;

(H) meets all applicable requirements of the laws of the State and of the locality in which it is situated;

(I) provides for examination of a patient by a physician within twenty-four hours of the time of his admission to it;

(J) provides for admission of a patient only after a certification by a physician that the patient requires care in such a facility;

(K) has a separate unit in the nursing home for the exclusive use of children; and

(L) meets such other requirements as the Board finds necessary in the interest of the health and safety of the individuals who are furnished services in such institution.

(5) "qualified home health agency" means an institution which, as determined in accordance with section 203—

(A) is a public or nonprofit organization, or subdivision thereof;

(B) provides skilled nursing, homemaker, home health and other medical and social services to assure patients' health and welfare in their homes;

(C) has written policies, established and periodically reviewed by a group including at least one physician and at least one registered nurse, governing its furnishing of services;

(D) has a full-time physician or full-time registered nurse supervising its furnishing of home health services;

(E) maintains clinical records on all its patients;

(F) meets all applicable requirements of the laws of the States and of the localities in which it furnishes services; and

(G) meets such other requirements as the Board finds necessary in the interest of the health and safety of the individuals who are furnished services in such institution.

(6) "qualified pathology laboratory" means a facility for the biological, microbiological, serological, chemical, immuno-hematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body, which meets all applicable requirements of the laws of the State and of the locality in which it is situated.

DETERMINATION OF QUALIFIED INSTITUTIONS

SEC. 203. (a) In determining the qualifications of an institution under section 202, the Board shall consult, pursuant to this section, with appropriate State agencies, recognized national listing or accrediting bodies, and health systems agencies (established pursuant to title XV of the Public Health Service Act).

(b) (1) The Board shall delegate, to the extent that the Board finds it appropriate, to a State health agency or other appropriate State agency (hereinafter in this subsection referred to as the "State health agency"), the function of determining whether or not an institution meets any or all of the qualifications of section 202.

(2) If the Board finds that accreditation of an institution by the Joint Commission on Accreditation of Hospi[illegible] the American Osteopathic Association, or any other natio[illegible] accrediting body provides reasonable assurance that any or all of the qualifications of section 202 are met, it may, to the extent it deems it appropriate, treat such institution or agency as meeting the qualification or qualifications with respect to which the Board made such finding.

(3) The Board may agree with the State health agency for such agency to survey—

(A) on a selective sample basis, or

(B) when the Board finds that a survey is appropriate because of substantial allegations of the existence of a significant deficiency or deficiencies, which, if found to be present, would adversely affect the health, welfare, or safety of patients,

any institution whose qualifications under section 202 are reviewed under subsection (b) (2) or section 303 (a) (2)

(A), and which has made an agreement with the Board pursuant to section 321 (b) (3).

(4) No later than sixty days after the completion, pursuant to paragraph (1) or (3), of a survey by a State health agency of the qualifications of an institution under this Act, the Board shall publish the findings of each such survey in a readily available manner.

(c) The Board shall pay the State health agency for the reasonable cost of performing functions authorized under subsection (b).

PART B—CHILDREN'S BENEFITS

COVERED PROFESSIONAL SERVICES

SEC. 211. (a) Except as provided in subsection (b), covered professional services shall include—

(1) preventive children's health services, and

(2) professional services for the diagnosis, treatment, or rehabilitation of a child following injury, disability, or disease.

(b) For the purposes of this section, covered professional services do not include—

(1) orthodontic services for children except for handicapping malocclusion;

(2) professional dental services for children under the age of four years;

(3) major surgery on a child not performed by a surgeon eligible or certified by a surgical specialty board;

(4) a tonsillectomy or adenoidectomy performed on a child without a second consultation by an independent physician as to the necessity for such surgery;

(5) any diagnostic or therapeutic procedure performed on a child without a second consultation by an independent physician as to the necessity for such diagnostic or therapeutic procedure, where the Board determines a second consultation respecting such procedure is appropriate or necessary for the health and welfare of the child; and

(6) psychiatric services except as provided under section 216 or except such inpatient psychiatric services as authorized pursuant to regulations established by the Board for the health and welfare of the child.

COVERED INPATIENT HOSPITAL SERVICES

SEC. 212. (a) Except as provided in subsections (b) and (c), covered inpatient hospital services shall include—

(1) inpatient services for a child of any age in any qualified hospital where a physician certifies, in accordance with regulations established by the Board, that the child requires emergency medical care;

(2) inpatient services for a child under the age of twelve yaers in a qualified pediatric unit; and

(3) inpatient services for a child of twelve years or older in a qualified hospital.

(b) For the purposes of this section, covered services do not include the services of a private duty nurse or attendant.

COVERED NURSING HOME SERVICES

SEC. 213. (a) Except as provided in subsection (b), covered nursing home services shall include inpatient services for a child in any qualified nursing home.

(b) Covered nursing home services under this section are limited to 120 days of inpatient services annually, but not more than 60 consecutive days in any one quarter.

COVERED HOME HEALTH SERVICES

SEC. 214. (a) Except as provided in subsection (b), covered home health care services shall include home health care services furnished by a qualified home health agency, where a physician certifies, in accordance with regulations established by the Board, that such services are necessary for the health and welfare of a child.

(b) Covered home health care services under this section are limited to 120 days of home health care services annually, except it may be waived when the limitation will result in the physician certifying that such limitation will require institutionalization of the child in accordance with regulations established by the Board.

COVERED DIAGNOSTIC SERVICES

SEC. 215. Covered diagnostic services shall include diagnostic services performed by a qualified pathology laboratory for a child who is not an inpatient in a hospital or in a nursing home.

COVERED REHABILITATIVE, SOCIAL, AND MENTAL HEALTH SERVICES

SEC. 216. (a) Except as provided in subsection (b), covered rehabilitative, social, and mental health services shall include—

(1) rehabilitative services, including physical therapy and speech therapy,

(2) social services, and

(3) mental health services, including psychiatric and psychological services,

furnished to a child who is not an inpatient in a hospital or nursing home, if furnished in a facility described in subsection (c), where a physician certifies, in accordance with regulations established by the Board, that such services are necessary for the health and welfare of a child.

(b) Covered rehabilitative, social, and mental health services under this section are limited as follows:

(1) rehabilitative services are limited to 60 visits, as defined by the Board, annually, and

(2) social and mental health services are limited to 60 visits, as defined by the Board, annually.

(c) A service described in subsection (a) is a covered service when furnished in a facility which—

(1) is run by a nonprofit or public organization, or subdivision thereof, and

(2) meets the applicable requirements of laws of the State and of the locality in which it is located.

COVERED DRUGS AND BIOLOGICALS

SEC. 217. (a) Covered drugs and biologicals shall include any drug or biological dispensed for use by a child who is not an inpatient in a hospital or nursing home, if—

(1) such drug or biological is required, by section 503(b) of the Federal Food, Drug, and Cosmetic Act, to be dispensed only upon prescription of a physician; and

(2) such drug or biological is prescribed to be taken by such child for a period of longer than ten therapeutic days.

(b) Covered drugs and biologicals shall also include insulin dispensed for use by a child who is not an inpatient in a hospital or nursing home.

COVERED DEVICES, APPLIANCES, AND EQUIPMENT

SEC. 218. (a) Except as provided in subsection (b), covered devices, appliances, and equipment shall include—

(1) the dispensing of such devices for the correction of the vision or hearing of a child, and

(2) the dispensing of such other medical devices, appliances, and equipment for the treatment or rehabilitation of a child following injury, disability, or disease,

as a physician certifies, in accordance with regulations established by the Board, to be necessary for the health and welfare of such child.

(b) The Board may, by regulation, exclude from covered devices, appliances, and equipment under subsection (a) the dispensing of such devices, appliances, and equipment as the Board determines to be ineffective, unreliable, unvalidated or not cost-justified in the prevention, treatment or rehabilitation of child injury, disability, or disease.

PART C—MATERNITY BENEFITS

COVERED PROFESSIONAL SERVICES

SEC. 221. Covered professional services shall include professional services—

(1) for the diagnosis and treatment of pregnancy, and

(2) for the diagnosis and treatment of any injury, disability, or disease during pregnancy, and

(3) for the diagnosis and treatment of any injury, disability, or disease related to pregnancy during the period of twelve weeks immediately following the pregnancy.

COVERED INPATIENT HOSPITAL SERVICES

SEC. 222. (a) Except as provided in subsection (b), covered inpatient hospital services shall include—

(1) inpatient services for a woman during pregnancy in any qualified hospital where a physician certifies, in accordance with regulations established by the Board, that the woman requires emergency medical care;

(2) inpatient services in a qualified hospital for a woman during the period of twelve weeks immediately following her pregnancy where a physician certifies, in accordance with regulations established by the Board, that the woman requires emergency medical care for the diagnosis or treatment of any injury, disability, or disease related to pregnancy; and

(3) inpatient services for a woman during pregnancy in any qualified obstetrical unit.

(b) For the purposes of this section, covered inpatient hospital services do not include the services of a private duty nurse or attendant.

COVERED DIAGNOSTIC SERVICES

SEC. 223. (a) Covered diagnostic services shall include diagnostic services performed by a qualified pathology laboratory—

(1) for a woman during pregnancy, and

(2) for a woman during the period of twelve weeks immediately following the pregnancy,

if such woman is not an inpatient in a hospital or in a nursing home.

(b) Covered diagnostic services shall include diagnostic services performed by a qualified pathology laboratory to determine whether or not a woman is pregnant.

COVERED DRUGS AND BIOLOGICALS

SEC. 224. Covered drugs and biologicals shall include any drug or biological dispensed for use by a woman during pregnancy or during the period of twelve weeks immediately following her pregnancy, if such woman is not an inpatient in a hospital or nursing home, and if—

(1) such drug or biological is required, by section 503 (b) of the Federal Food, Drug, and Cosmetic Act, to be dispensed only upon prescription of a physician,

and such drug or biological is prescribed to be taken by such woman for a period of longer than ten therapeutic days, or

(2) such drug is insulin.

COVERED DEVICES, APPLIANCES, AND EQUIPMENT

SEC. 225. (a) Except as provided in subsection (b), covered devices, appliances, and equipment shall include the dispensing of such devices, appliances, and equipment as a physician may certify, in accordance with regulations established by the Board, as required for the treatment of a woman for any condition related to pregnancy during pregnancy or during the period of twelve weeks immediately following her pregnancy.

(b) The Board may, by regulation, exclude from covered devices, appliances, and equipment under subsection (a) the dispensing of such devices, appliances, and equipment as the Board determines to be ineffective, unreliable, unvalidated, or not cost-justified in the treatment of a condition [illegible]ed to pregnancy.

PART D—SPECIAL POPULATION BENEFITS

PURPOSE

SEC. 231. The purpose of this part is to furnish additional covered support services to individuals residing in inaccessible areas or who are otherwise unlikely to use the other services covered under this Act in order to promote the appropriate use of services under this Act by all individuals, regardless of race, income, health status, or location of residency.

SPECIAL POPULATION

SEC. 232. (a) The Board to the maximum extent feasible shall arrange for the furnishing of the covered support services, described in section 233, to individuals—

(1) who reside in a health manpower shortage area, as determined by the Board, or

(2) who, because of poverty, discrimination, or cultural barriers, are determined by the Board to suffer a higher risk of infant and maternal morbidity and mortality than other individuals.

(b) For the purposes of subsection (a), the term "health manpower shortage area" means—

(1) an area in an urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health care) which the Board determines has a health manpower shortage, or

(2) a population group which the Board determines has such a shortage.

COVERED SUPPORT SERVICES

SEC. 233. (a) Covered support services shall include, with respect to an individual described in section 232 (a)—

(1) transportation of such individual (and, if such individual is a child, the parent or guardian of such child) to and from a person furnishing covered services to such individual under this Act;

(2) care of a dependent while such individual is being furnished covered services under this Act;

(3) social outreach assistance to inform such individual about and to assist such individual in receiving covered services furnished under this Act; and

(4) such similar services provided on behalf of such individual as the Board determines as necessary and appropriate to the purposes of this part,

if such services are provided by a person described in subsection (b).

(b) A support service described in subsection (a) is a covered service when furnished—

(1) under the supervision of a qualified institution, or

(2) by or under the supervision of a public or private nonprofit organization determined by the Board to have the organizational and financial capability to fur-

nish such service on a dependable and fiscally responsible basis.

TITLE III—ADMINISTRATION AND METHOD OF PAYMENT OF BENEFITS

PART A—ADMINISTRATION AND GENERAL PROVISIONS

DEFINITIONS

SEC. 301. For the purposes of this title, the term—

(1) "carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization;

(2) "fee payment area" means an area designated by the Secretary, pursuant to section 1152(a) of the Social Security Act (42 U.S.C. 1320c–1), as appropriate with respect to the establishment of Professional Standards Review Organizations;

(3) "fee payment schedule" means a schedule, approved in accordance with section 312, of the amount

of payments for the provision under this Act of various covered professional services;

(4) "covered institutional services" means—

(A) covered inpatient hospital services,

(B) covered nursing home services,

(C) covered home health care services,

(D) covered rehabilitative, social, and mental health services, and

(E) covered diagnostic services;

(5) "qualified institution" means—

(A) a qualified hospital,

(B) a qualified nursing home,

(C) a qualified home health agency,

(D) a facility described in section 216(a)(3), and

(E) a qualified pathology laboratory;

(6) "prospective rate schedule" means a schedule, approved in accordance with section 322, of the amount of payments for the provisions under this Act of various covered institutional services; and

(7) "person" includes a qualified institution.

DELEGATION OF SECRETARY'S AUTHORITY

SEC. 302. To the extent he deems it consistent with the purposes of this Act, the Secretary may delegate his authority for the administration of the system of payments or eligibility for benefits provided for in this title to the Administrator of the Social Security Administration.

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 303. (a) In order to provide for the administration of the benefits under this Act with maximum efficiency and convenience for individuals eligible for benefits under this Act and for persons furnishing services to such individuals, the Secretary is authorized, after consultation with the Board, to enter into contracts with carriers as defined in section 301 (i) to perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations) —

(1) (A) determine the amounts of payments required to be made under this Act;

(B) receive, disburse, and account for funds in making such payments;

(C) assist persons furnishing services under this Act in establishing and maintaining fiscal records necessary for purposes of this Act; and

(D) make such audits of the records of persons furnishing services as may be necessary to assure that proper payments are made under this Act;

(2) (A) determine compliance with the qualifications of section 202, and

(B) assist persons who furnish services for which payment may be made under this Act, in the development of procedures relating to utilization practices, make studies of the effectiveness of such procedures and methods for their improvement, assist in the application of safeguards against unnecessary utilization of services furnished by persons to individuals eligible for benefits under this Act, and provide procedures for and assist in arranging where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1861(k)(2) of the Social Security Act) to make reviews of utilization;

(3) serve as a channel of communication of information relating to the administration of this Act; and

(4) otherwise assist, in such manner as the contract may provide, in discharging administrative duties necessary to carry out the purposes of this Act.

(b)(1) Contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

(2) No such contract shall be entered into with any carrier unless the Secretary finds that during the year 1976 at least 3 percent of the total dollar value of health insurance

outstanding in the United States was written or underwritten by such carrier.

(3) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

(c) Each such contract shall provide that—

(1) where the carrier has agreed to make payments under this Act—

(A) the carrier shall establish and maintain procedures by which a person furnishing services covered under this Act will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more—

(i) when requests for payment for such services under this Act are denied or are not acted upon with reasonable promptness, or

(ii) when the amount of such payments is in controversy;

(B) the carrier shall use such standard forms and procedures for requests for payment as the Board may prescribe to minimize administrative work of physicians and others furnishing services covered under this Act;

(C) the Secretary shall advance funds to the carrier for the making of payments under this Act; and

(2) the carrier shall furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this Act; and

(3) the carrier shall maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under paragraph (2) and otherwise to carry out the purposes of this Act;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate.

(c) (1) Except as provided in paragraph (2), each contract shall be for a term of at least two years, and may be made automatically renewable from term to term in the absence of notice by either party of its intention not to renew the contract at the end of the current term.

(2) Each contract may be terminated—

(A) by the carrier at such time and upon such notice to the Secretary, to the Board, to the public, and to persons furnishing services under this Act, as the Secretary establishes by regulation, and

(B) by the Secretary at any time, after such reasonable notice to the carrier, the Board ,the public, and to persons furnishing services under this Act and after such opportunity for a hearing to the carrier as the Secretary establishes by regulation, if the Secretary finds that—

(i) the carrier has failed substantially to carry out the contract, or

(ii) the carrier is carrying out all or some of the duties provided for in the contract in a manner inconsistent with the effective and efficient administration of this Act.

(d) (1) Any contract with a carrier under this section may require such carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(2) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States,

be liable with respect to any payments certified by him under this section.

(3) No individual designated pursuant to a contract under this section as a disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this seciton if it was based upon a voucher signed by an individual designated pursuant to a contract under this section as a certifying officer.

(4) No such carrier shall be liable to the United States for any payments referred to in paragraph (2) or (3).

LIMITATION ON PAYMENTS

SEC. 304. (a) Payment for a covered service furnished under this Act may be made only—

(1) to the person furnishing such service,

(2) to the employer of such person, if such person has an agreement to turn over such payments to his employer, or

(3) to the facility in which such service was provided, if there is an agreement between such person and facility under which the facility receives payments for such person's services.

(b) No payment may be made for covered institutional services furnished by a person prior to the Board's determination that such person is a qualified institution.

COPAYMENT FOR CERTAIN COVERED SERVICES

SEC. 305. (a) The Secretary shall pay 100 per centum of the full payment amount if—

(1) such covered service is other than one of the following:

(A) a home health service;

(B) a covered device, equipment, or appliance, described in section 218 or 225, or

(C) a covered professional service, other than preventive children's health services, furnished to a child; or

(2) such covered service is furnished under a fee schedule described in section 312(a)(2) (relating to capitation methods); or

(3) the individual to whom such covered service is furnished (or, if the individual is a child, the parent or guardian of such child)—

(A) has an income below the poverty level, as determined by the Board, or

(B) is eligible in the State in which he resides for any benefits under title XIX of the Social Security Act (relating to medicaid).

(b) Except as provided in subsection (a), the Secretary shall pay 90 per centum of the full payment amount.

(c) For the purposes of this section, the term "full payment amount" means the amount specified in a schedule established pursuant to this title as representing full payment for the furnishing of any covered service.

SIMPLIFIED REQUEST FOR PAYMENT PROCEDURES

SEC. 306. The Secretary and the Board shall provide, to the extent consistent with the efficient administration of this Act, for the consolidation and standardization of simple forms and procedures which a physician, physician extender, or qualified institution must complete in order to request and receive payment for furnishing covered professional and institutional services under this Act.

PROHIBITION OF AND CONDITIONS FOR PAYMENTS

SEC. 307. (a) If the Board determines, after a hearing, held in accordance with subchapter II of chapter 5 of title 5, United States Code (Administrative Procedure Act), that a person furnishing covered services under this Act has—

(1) substantially or consistently violated the terms of an agreement required under the provisions of this title, or

(2) has substantially or consistently violated requirements for such person under this title,

the Board may prohibit, for such period, not to exceed one year, as it may deem appropriate, the making of any payments under this Act with respect to the furnishing of covered services by such person after the determination by the Board.

(b) If the Board determines, after a hearing held in accordance with subchapter II of chapter 5 of title 5, United States Code (Administrative Procedure Act), that a person furnishing covered services under this Act has violated an agreement containing the provisions of section 311(c)(2), 311(d)(1)(A), 311(d)(2), 321(b)(2), 321(c)(2), 332(c)(2), or 332(d)(1), the Board may require, as a condition for such person having payments made under this Act for services furnished after the date of such determination, that such person provide an appropriate arrangement for the refunding of those fees and charges which were collected in violation of the applicable provisions of such sections.

PART B—PAYMENT FOR COVERED PROFESSIONAL SERVICES

GENERAL PROVISIONS

SEC. 311. (a) Payments shall be made by the Secretary for the furnishing of covered professional services in accordance with part A and this part.

(b)(1) In accordance with procedures established by the Secretary, after consultation with the Board, any person intending to request payment for its furnishing of covered professional services under this Act shall notify the Secretary of such intention at least thirty days prior to submittal of the first request for payment for such person.

(2) The Board shall make available, in such manner and form and at such times as the Board may consider appropriate, to the public the name, address, and telephone number of each person who has filed, pursuant to paragraph (1), notice of his intent to request payment for the furnishing of covered professional services under this Act.

(c) Any person furnishing covered professional services who intends to request payment under this Act for furnishing such services shall—

(1) display, in a manner prescribed by the Board, public notice of its participation in the program under this Act; and

(2) inform each patient (or if the patient is a child, the parent or guardian of such patient), prior to the furnishing of such services, the amount of any copayment the patient (or parent or guardian of such patient) must make for such services.

(d) (1) No payment shall be made pursuant to this Act to a person furnishing a covered professional service unless that person agrees—

(A) except as provided in section 313, to accept the amount specified in the appropriate fee payment schedule, established in accordance with section 312, as full payment for such services, and

(B) to provide such information, as the Secretary may require by regulation, to verify the service or services furnished.

(2) No payment shall be made pursuant to a fee payment schedule described in section 312(a)(2) (relating to capitation payments) unless the person receiving payment pursuant to such schedule furnishes in an appropriate manner, determined by the Board, all services covered under such schedule, or has arranged, in an appropriate manner, determined by the Board, for the furnishing of all such services as it is not qualified to furnish.

(e) (1) Timely payment under this Act based on a fee payment schedule described in section 312(a)(1) (relating to fee for service) shall be made in accordance with this Act after the furnishing of the service covered in such schedule.

(2) Timely payment under this Act based on a fee payment schedule described in section 312(a)(2) (relating to capitation fees) shall be made in such a manner, to be determined by the Board, as to reflect the timing of normal furnishing of services to individuals receiving the care described in such section under this Act.

APPROVAL OF FEE PAYMENT SCHEDULES

SEC. 312. (a) In accordance with this section, the Board shall approve for each fee payment area a schedule of the amount of payments to be made under this Act for the furnishing of various covered professional services, and shall include—

(1) a fee payment schedule for the furnishing of individual services, and

(2) a fee payment schedule for the payment—

(A) of a single amount for the furnishing of prepaid pediatric care (as defined in subsection (f) (1)) for a period of not less than one year, as specified by the Board, and

(B) of a single amount for the furnishing of prepaid maternity care (as defined in subsection (f) (2)).

(b) For the purposes of this section, the Board shall designate for each fee payment area a fee payment board (hereinafter in this section referred to as the "fee payment board") which shall be—

(1) a nonprofit organization (or component thereof),

(2) composed of individuals furnishing covered professional services in such area, and

(3) open for membership to all individuals furnishing such professional services in such area.

(c) Each fee payment board shall submit to the Board a proposed fee payment schedule no later than 18 months after the date of enactment of this Act. Each such board may submit to the Board a proposed revision of such schedule once every year and at such other times as the Board, after consultation with the Secretary, may deem appropriate to the administration of this Act.

(d) (1) The Board shall approve a proposed fee payment schedule or a proposed revision thereof if it finds that such schedule or revision, except as provided in paragraph (2), reflects the prevailing fee for service or services in the fee payment area as of December 31, 1974, as adjusted according to such economic index or indices as the Board determines to be appropriate.

(2) A fee schedule described in subsection (a) (2) (relating to capitation payments) may provide for the payment of an amount, not to exceed by more than 10 per centum the amount otherwise payable under this subsection, in addition to the amount otherwise payable under this subsection.

(3) Where a fee payment schedule has not been proposed for a fee payment area, or where the Board does not

approve a proposed schedule, the Board shall approve as a fee payment schedule for such area—

(A) a schedule which reflects an approved schedule for an area similar in economic characteristics to the area involved, or

(B) where the Board determines that an area of similar economic characteristics does not exist, a schedule which, except as provided in paragraph (2) of this subsection, reflects the prevailing fee for service or services in the fee payment area as of December 31, 1974, as adjusted according to such economic index or indices as the Board determines to be appropriate.

(4) No later than one month before approval of a proposed schedule, and within one month after approval of a schedule, the Board shall publish notice of such schedule in the fee payment area covered by such schedule.

(e) Persons adversely affected by the Board's approval or disapproval of a fee payment schedule under this section may seek review of such approval or disapproval under the procedures provided in subchapter II of chapter 5 of title 5, United States Code (Administrative Procedure Act).

(f) As used in this section, the term—

(1) "prepaid pediatric care" means covered professional services under section 211 including—

(A) preventive children's health services, and

(B) such other health services as may be determined by the Board as appropriate for the diagnosis and treatment of common pediatric conditions; and

(C) evidence of arrangements for the referral for diagnosis or treatment of other than common pediatric conditions, pursuant to regulations established by the Board.

(2) "prepaid maternity care" means covered professional services under section 221 including—

(A) such professional services as the Board determines are ordinary and appropriate in a normal maternity case, and

(B) evidence of arrangements for the referral for diagnosis or treatment of other than normal maternity care, pursuant to regulations established by the Board.

DEMONSTRATION METHODS OF PAYMENT

SEC. 313. (a) In lieu of payment pursuant to section 312, a fee payment board may propose and the Board may approve, on an experimental or demonstration basis for a period not to exceed two years, a method of payment for covered professional services furnished under this Act, if the Board determines that the total amount of payments under such method will not exceed the total amount of payments which would otherwise be made under this applicable fee payment schedule.

(b) The Board shall report to Congress on the results of any experiments or demonstrations under subsection (a), and include in such report such recommendations for changes in the methods of payment under this Act as the Board determines are appropriate.

PART C—PAYMENT FOR COVERED INSTITUTIONAL SERVICES

GENERAL PROVISIONS

SEC. 321. (a) Payments shall be made on a timely basis and in accordance with part A and this part by the Secretary for covered institutional services.

(b) No payment shall be made under this Act to a qualified institution furnishing covered institutional services unless such institution—

(1) has submitted and has had approved by the Board a prospective rate schedule, in accordance with section 322;

(2) agrees to accept the amount specified in such schedule as full payment for such services; and

(3) agrees to provide such information, as the Secretary may require by regulation, to verify its qualifications as a qualified institution and to verify the services furnished under this Act.

(c) Any qualified institution which has had a prospective rate schedule, for its furnishing of covered institutional services, approved pursuant to section 322, and which intends to request payment under this Act for furnishing such services shall—

(1) display, in a manner prescribed by the Board, public notice of its participation in the program under this Act, and

(2) inform each patient (or if patient is a child, the parent or guardian of such patient), prior to the furnishing of such services, the amount of any copayment the patient (or parent or guardian of such patient) must make for such services.

APPROVAL OF PROSPECTIVE RATE SCHEDULES

SEC. 322. (a) (1) The Board, after consultation with the Secretary, qualified institutions, carriers, and other interested parties and organizations, shall establish one or more methods (hereinafter in this section referred to as "methods"), which satisfy the criteria of subsection (b), for the establishment of a prospective rate schedule for the payment of qualified institutions furnishing covered institutional services under this Act.

(2) The Board may modify or eliminate a method or methods established under paragraph (1) where it determines, after consultation with qualified institutions which

have submitted to the Board a proposed prospective rate schedule based on such method, and with the Secretary, carriers, and other interested parties and organizations, that—

(A) such method or methods are inconsistent with the provisions of subsection (b), or

(B) are inconsistent with the efficient administration or purposes of this Act.

(3) Any modification or elimination of a method or methods pursuant to paragraph (2) shall take effect, with respect to a qualified institution which has submitted to the Board a proposed prospective rate schedule based on such method, no earlier than six months after the Board has notified such institution of such modification or elimination of such method or methods.

(b) Any method established by the Board pursuant to subsection (a) for payment of qualified institutions for furnishing covered institutional services shall provide—

(1) for the establishment of rates of payments for such services in advance of the time when such services are furnished and without regard to costs actually incurred in furnishing such services;

(2) for the revision of such rates no more frequently than once every year, unless the Board determines that more frequent adjustments are appropriate due to significant unforeseeable events, including—

(A) natural disasters and catastrophes,

(B) epidemics,

(C) major economic dislocations not under the control of the institution furnishing such services, and

(D) significant changes in patient mix not under the control of the institution furnishing such services;

(3) financial incentives for improved efficiency in the furnishing of such services by sharing savings with qualified intitutions that perform at lower than anticipated costs;

(4) incentives for retrospectively validated improved quality in the furnishing of covered services;

(5) for a reasonable return on investment based on a rate of return on investment of comparable risk and computed at the time such prospective rate schedule is established; and

(6) for payment of such portion of the operation and administration (including the financing of capital improvements), of such qualified institution's program as is necessary for the furnishing of such services, and, if subject to review by a health systems agency under section 1513 (a) (1) (A) of the Public Health Services Act, as has been approved by such agency.

(c) Each person who intends to request payment for the furnishing of covered institutional services pursuant to this Act—

(1) shall submit to the Board a proposed prospective rate schedule for the furnishing of such services based on a method established by the Board pursuant to this section, and

(2) may submit to the Board, after such schedule has become effective, a proposed revision of such schedule—

(A) once every year,

(B) when the Board modifies or eliminates a method, pursuant to subsection (a) (2), upon which such schedule has been based, and

(C) at such other times as the Board, after consultation with the Secretary, determines is consistent with subsection (b) (2) and is appropriate for the administration of this Act.

(d) (1) Unless the Board, no later than sixty days after the date of the submittal of a proposed prospective rate schedule or a proposed revision thereof, finds that such schedule or revision is inconsistent with a method established by the Board, such schedule or revision thereof shall become effective sixty days after the date of such submittal.

(2) No later than ten days after the date a proposed rate schedule or a revision thereof is submitted to the Board,

the person submitting the proposal shall publish such proposed schedule or revision in such region affected by the proposal and in such a manner as the Board may determine is appropriate to carry out the purposes of this Act.

(e) Persons adversely affected by the Board's approval or disapproval of a prospective rate schedule or revision thereof under this section may seek review of such approval or disapproval under the procedures provided in subchapter II of chapter 5 of title 5, United States Code (Administrative Procedure Act).

PART D—PAYMENT FOR DRUGS, DEVICES, AND SPECIAL POPULATION BENEFITS

DEFINITIONS

SEC. 331. As used in this part, the term—

(1) "dispenser" means any person who has notified the Secretary, pursuant to section 332(b)(1), of his intention to request payment under this Act for the dispensing of covered drugs and devices; and

(2) "covered drugs and devices" means covered drugs and biologicals, and covered devices, appliances, and equipment.

PAYMENT FOR COVERED DRUGS AND DEVICES

SEC. 332. (a) Payments shall be made by the Secretary for the dispensing of covered drugs and devices in accordance with part A and this part,

(b) (1) In accordance with procedures established by the Secretary, after consultation with the Board, any person intending to request payment for its dispensing of covered drugs and devices under this Act shall notify the Secretary of such intention at least thirty days prior to submittal of the first request for payment for such person.

(2) The Board shall make available, in such manner and at such times as the Board may consider appropriate, to the public the name, address, and telephone number of each dispenser.

(c) Each dispenser shall—

(1) display, in a manner prescribed by the Board, public notice of its participation in the program under this Act; and

(2) inform each patient (or if the patient is a child, the parent or guardian of such patient), prior to the dispensing of such drugs or devices, the amount of any copayment the patient (or the parent or guardian of such patient) must make for such drugs or devices.

(d) No payment shall be made pursuant to this Act to a dispenser unless that person agrees—

(1) to accept the amount specified in accordance with subsection (e), as full payment for the dispensing of such drug or device, and

(2) to provide such information, as the Secretary

may require by regulation, to verify the drug or device dispensed.

(e) The amount of payment made under this Act for the dispensing of a covered drug or device shall be the sum of—

(1) the wholesale cost of such drug or device, as determined under the schedule adopted pursuant to subsection (f), and

(2) a fee for the dispensing of such drug or device (hereinafter in this section referred to as a "dispensing fee"), as determined under the schedule adopted pursuant to subsection (g).

(f) (1) The Board shall determine and publish, no less often than annually, a schedule of the wholesale cost of covered drugs and devices commonly dispensed under this Act, and shall establish by regulation procedures for determination of the wholesale cost of covered drugs and devices not commonly dispensed under this Act.

(2) The Board may provide in such schedule for variations in the wholesale cost to reflect differences in costs to a dispenser as a result of differences in size of the dispenser and differences in the regional location of the dispenser.

(g) (1) A dispenser requesting payment under this part shall submit to the Board, in a form prescribed by the Board, a proposed schedule of dispensing fees.

(2) Such schedule may be revised once every year and at such other times as the Board, after consultation with the Secretary, determines is consistent with the administration of this Act.

(3) The Board shall approve such proposed schedule or proposed revision thereof unless, no later than sixty days after the submittal of such proposed schedule or of a proposed revision thereof, it finds that the dispensing fees in such schedule or revision are not in excess of a percentage of the schedule of wholesale costs (determined pursuant to subsection (f)) sufficient to compensate the dispenser for the reasonable costs of dispensing such drug or device.

(4) No dispensing fee shall be approved under this section if the dispenser is a physician, unless the Board determines that there is no dispenser (other than a physician) in the community in which such physician requests to dispense covered drugs or devices.

PAYMENT FOR SPECIAL POPULATION BENEFITS

SEC. 333. (a) Payments shall be made by the Secretary for the furnishing of covered support services in accordance with part A and this section.

(b) The Board shall establish mechanisms to reimburse to persons described in section 233(b) for the furnishing of covered support services in such reasonable amounts as the

Board determines are necessary and appropriate for the efficient furnishing of such services.

TITLE IV—COMPREHENSIVE MATERNAL AND CHILD HEALTH PRACTICE

PART A—ASSISTANCE FOR COMPREHENSIVE MATERNAL AND CHILD HEALTH PRACTICE

FINDINGS AND DECLARATION OF PURPOSE

SEC. 401. (a) The Congress hereby finds and declares that improving the provision and the delivery of health care to mothers and children is of critical importance and of the highest national priority and that present programs of health services do not provide for such continuing, efficient, and comprehensive health care, and lead to an unnecessary duplication of facilities, equipment, and personnel.

(b) It is the purpose of this title to provide financial and technical assistance through loans, grants, supplementary financing and otherwise to health service institutions and organizations which will stimulate and enable such institutions and organizations to plan, develop, and implement comprehensive maternal and child health practice.

SEC. 402. (a) For purposes of this title, the term "comprehensive maternal and child health practice" means a legal entity which is organized and operated in the following manner:

(1) Except for an entity which will provide medical services for special populations (as defined in section 232)—

(A) the entity shall provide medical services by at least five health professionals licensed to practice medicine or osteopathy;

(B) of the health professionals providing services for the entity, at least one-half or three, whichever is greater, shall be health professionals engaged in family practice or general pediatrics practice;

(C) the principal source of professional practice income for a majority of the health professionals shall be required to be derived from covered professional services provided through their relationship to the entity; and

(D) the entity providing medical services to a special population shall provide medical services through at least three health professionals who are licensed to practice medicine or osteopathy and two of whom are engaged in family practice or general pediatric practice.

(2) The entity shall offer a comprehensive range of pediatric obstetrical services reasonably expected to meet the majority of the medical needs of the women and children which it serves. These services shall include

covered professional services (including consultant and referral services by a physician), medically necessary emergency health services, diagnostic laboratory services, and preventive health and health education services.

(3) The entity shall offer each of its patients a readily identifiable individual who shall either be a physician or other licensed or certified health professional and who shall be primarily responsible for continuity in the care provided the patient by the entity.

(4) The members of the entity shall share equipment, facilities, and professional, technical, and administrative personnel.

(5) The entity shall—

(A) maintain a unitary record system,

(B) provide for a system of assurance of the quality of medical care delivery through the entity,

(C) meet applicable standards of accreditation of the American Group Practice Association or the Council on Ambulatory Care of the Joint Commission on the Accreditation of Hospitals, and

(D) operate under a unitary administrative structure which includes billing services and opportunities for patients to register and resolve grievances regarding billing or the quality of medical care through the entity.

(6) The entity shall maintain an information program for the residents of its medical service area which fully discloses—

(A) the covered professional services offered through the entity, and

(B) the method by which patients of the entity may resolve grievances respecting billing for covered professional services or the quality of the covered professional services.

(7) The entity shall to the extent feasible use such additional professional personnel (including physician extenders'), allied health professions personnel and other health personnel (as specified in regulations of the Secretary) as are available and appropriate for the effective and efficient delivery of the services to patients.

PRIORITIES FOR GRANTS AND CONTRACTS

SEC. 403. In providing any assistance under this title the Secretary shall give a priority to grants and contracts which will establish an entity that will provide 'covered professional services' through a fee payment schedule defined under section 312(a)(2).

GRANTS AND CONTRACTS FOR FEASIBILITY SURVEYS

SEC. 404. (a) The Secretary may make grants to public and nonprofit private entities and enter into contracts with public and private entities for projects for surveys or other activities to determine the feasibility of—

(1) developing and operating comprehensive maternal and child health practices, or

(2) expanding significantly the operation of existing comprehensive maternal and child health practices.

(b) An application for a grant or contract under subsection (a) shall contain assurances satisfactory to the Board that, in conducting surveys or other activities with the assistance of a grant or contract under such subsection the applicant will cooperate with the health systems agency defined under section 1512 of the Public Health Service Act) whose health service area (defined in section 1511 of the Public Health Service Act) covers (in whole or in part) the area for which the survey or other activity will be conducted.

(c) Of the sums appropriated for any fiscal year under section 409 for grants and contracts under this section, not less than 20 percent shall be set aside and obligated each fiscal year for projects to determine the feasibility of developing and operating or expanding the operation of comprehensive maternal and child health practices which the Board determines may reasonably be expected to have after their development or expansion not less than two-thirds of their patients drawn from residents of special populations, defined in section 232.

GRANTS, CONTRACTS, AND LOAN GUARANTEES FOR PLANNING AND FOR INITIAL DEVELOPMENT COSTS

SEC. 405. (a) The Secretary may—

(1) make grants to public and nonprofit private entities and enter into contracts with public and private entities for planning projects for—

(A) the establishment of comprehensive maternal and child health practices, or

(B) the significant expansion of comprehensive maternal and child health practices; and

(2) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to private entities for planning projects for the establishment of comprehensive maternal and child health practices or for the significant expansion of comprehensive maternal and child health practices.

(b) The Secretary may—

(1) make grants to public and nonprofit private entities and enter into contracts with public and private

entities for projects for the initial development of comprehensive maternal and child health practices; and

(2) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to any private entity for projects for the initial development of comprehensive maternal and child health practices.

(c) In considering applications for grants, contracts, or loan guarantees under subsection (a) or (b)—

(1) the Secretary may not approve such an application unless it contains or is supported by assurances satisfactory to the Secretary that, at the time the comprehensive maternal and child health practice for which such application is submitted first becomes operational after its development or expansion, it will cooperate in the conduct of the studies authorized by part D; and

(2) the Secretary shall in addition to the priority established under section 403 give priority to an application which contains or is supported by assurances satisfactory to the Secretary that, at the time the comprehensive maternal and child health practice for which such application is submitted first becomes operational after its development or expansion, it will serve a special population.

(d) (1) The cumulative total of the principal of the loans outstanding at any time with respect to which guarantees have been issued under subsection (a) or (b) may not exceed such limitations as may be specified in appropriation Acts.

(2) Loan guarantees under subsection (a) or (b) may be made through the fiscal year ending September 30, 1980.

(3) The aggregate amount of principal of loans guaranteed under subsection (a) or (b) for any project may not exceed $1,000,000.

LOANS AND LOAN GUARANTEES FOR INITIAL OPERATIONS COSTS

SEC. 406. (a) The Secretary may—

(1) make loans to comprehensive maternal and child health practices to assist them in meeting the amount by which their operating costs in the period of the first thirty-six months of their operation exceed their revenues in that period;

(2) make loans to comprehensive maternal and child health practices to assist them in meeting the amount by which their operating costs, which the Secretary determines are attributable to significant expansion in patients served and which are incurred in the period of the first thirty-six months of their operation after such expansion, exceed their revenues in that period which the Secretary determines are attributable to such expansion; and

(3) guarantee to non-Federal lenders payment to the principal of and the interest on loans made to any private comprehensive medical practice for the amounts referred to in paragraph (1) or (2).

(b) In considering applications for loans or loan guarantees under subsection (a), the Secretary shall give special consideration to an application which contains or is supported by assurances satisfactory to the Secretary that the comprehensive maternal and child health practice for which the application is submitted will serve a special population.

(c) (1) The cumulative total of the principal of the loans outstanding at any time which have been directly made or with respect to which guarantees have been issued under subsection (a) may not exceed such limitations as may be specified in appropriation Acts.

(2) Loans under subsection (a) shall be made from the fund established under section 408.

(3) The cumulative total of the principal of the loans outstanding at any time with respect to which guarantees have been issued under subsection (a) may not exceed such limitations as may be specified in appropriation Acts.

(4) Loans and loan guarantees under subsection (a) may be made through the fiscal year ending September 30, 1980.

ADMINISTRATION OF PART A

SEC. 407. (a) No grant, contract, loan, or loan guarantee may be made under this part unless an application therefor has been submitted to and approval by the Secretary.

(b) Payments under grants and contacts under this section may be made in advance or by way of reimbursement and at such intervals and on such conditions as the Secretary finds necessary.

GENERAL PROVISIONS RELATING TO LOAN GUARANTEES AND LOANS

SEC. 408. (a) (1) The Secretary may not approve an application for a loan guarantee under this part unless he determines that (A) the terms, conditions, security (if any), and schedule and amount of repayments with respect to the loan are sufficient to protect the financial interests of the United States and are otherwise reasonable, including a determination that the rate of interest does not exceed such per centum per annum on the principal obligation outstanding as the Secretary determines to be reasonable, taking into account the range of interest rates prevailing in the private market for similar loans and the risks assumed by the United States, and (B) the loan would not be available on reasonable terms and conditions without the guarantee under this part.

(2) (A) The United States shall be entitled to recover

from the applicant for a loan guarantee under this part the amount of any payment made pursuant to such guarantee, unless the Secretary for good cause waives such right of recovery; and, upon making any such payment, the United States shall be subrogated to all of the rights of the recipient of the payments with respect to which the guarantee was made.

(B) To the extent permitted by subparagraph (C), any terms and conditions applicable to a loan guarantee under this part (including terms and conditions imposed under subparagraph (D)) may be modified by the Secretary to the extent he determines it to be consistent with the financial interest of the United States.

(C) Any loan guarantee made by the Secretary under this part shall be incontestable (i) in the hands of an applicant on whose behalf such guarantee is made unless the applicant engaged in fraud or misrepresentation in securing such guarantee, (ii) as to any person (or his successor in interest) who makes or contracts to make a loan to such applicant in reliance thereon unless such person (or his successor in interest) engaged in fraud or misrepresentation in making or contracting to make such loan.

(D) Guarantees of loans under this part shall be subject to such further terms and conditions as the Secretary determines to be necessary to assure that the purposes of this part will be achieved.

(b) (1) The Secretary may not approve an application for a loan under this part unless—

(A) the Secretary is reasonably satisfied that the applicant therefor will be able to make payments of principal and interest thereon when due, and

(B) the applicant provides the Secretary with reasonable assurances that there will be available to it such additional funds as may be necessary to complete the project or undertaking with respect to which such loan in requested.

(2) Any loan made under this part shall—

(A) have such security,

(B) have such maturity date,

(C) be repayable in such installments,

(D) bear interest at a rate comparable to the current rate of interest prevailing, on the date the loan is made, with respect to loans guaranteed under this part, and

(E) be subject to such other terms and conditions (including provisions for recovery in case of default), as the Secretary determines to be necessary to carry out the purposes of this part while adequately protecting the financial interests of the United States.

(3) The Secretary may, for good cause but with due regard to the financial interests of the United States, waive any right of recovery which he has by reason of the failure of a borrower to make payments of principal of and interest on a loan made under this part, except that if such loan is sold and guaranteed, any such waiver shall have no effect upon the Secretary's guarantee of timely payment of principal and interest.

(c) (1) The Secretary may from time to time, but with due regard to the financial interests of the United States, sell loans made by him under this part.

(2) The Secretary may agree, prior to his sale of any such loan, to guarantee to the purchaser (and any successor in interest of the purchaser) compliance by the borrower with the terms and conditions of such loan. Any such agreement shall contain such terms and conditions as the Secretary considers necessary to protect the financial interests of the United States or as otherwise appropriate. Any such agreement may (A) provide that the Secretary shall act as agent of any such purchaser for the purpose of colleting from the borrower to which such loan was made and paying over to such purchaser, any payments of principal and interest payable by such organization under such loan; and (B) provide for the repurchase by the Secretary of any such loan on such terms and conditions as may be

specified in the agreement. The full faith and credit of the United States is pledged to the payment of all amounts which may be required to be paid under any guarantee under this paragraph.

(3) After any loan under this part to a public comprehensive maternal and child health practice has been sold and guaranteed under this subsection, interest paid on such loan which is received by the purchaser thereof (or his successor in interest) shall be included in the gross income of the purchaser of the loan (or his successor in interest) for the purpose of chapter 1 of the Internal Revenue Code of 1954.

(4) Amounts received by the Secretary as proceeds from the sale of loans under this subsection shall be deposited in the loan fund established under subsection (e).

(d) There is established in the Treasury a loan guarantee fund (hereinafter in this subsection referred to as the "fund") which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts, to enable him to discharge his responsibilities under loan guarantees issued by him under this part. There are authorized to be appropriated from time to time such amounts as may be necessary to provide the sums required for the fund. To the extent authorized in appropriation Acts, there shall also be deposited in the fund amounts received by the Secretary in connection with loan guarantees under this part and other property or assets derived by him from his operations respecting such loan guarantees, including any money derived from the sale of assets.

(e) There is established in the Treasury a loan fund (hereinafter in this subsection referred to as the "fund") which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts, to enable him to make loans under this part. There shall also be deposited in the fund amounts received by the Secretary as interest payments and repayment of principal on loans made under this part and other property or assets derived by him from his operations respecting such loans, from the sale of loans under subsection (c) of this section, or from the sale of assets.

AUTHORIZATION OF APPROPRIATIONS

SEC. 409. (a) For payments under grants and contracts under sections 404(a)(1), 405(a)(1)(A), and 405(b) there are authorized to be appropriated $5,500,000 for the fiscal year ending September 30, 1978, $6,000,000 for the fiscal year ending September 30, 1979, and $7,000,000 for the fiscal year ending September 30, 1980.

(b) For payment under grants and contracts under sections 404(a)(2) and 405(a)(1)(B) there are authorized to be appropriated $20,000,000 for the fiscal year ending September 30, 1978, $25,000,000 for the fiscal year ending September 30, 1979, and $30,000,000 for the fiscal year ending September 30, 1980.

PART B—MEDICAL MALPRACTICE REINSURANCE PROGRAM FOR COMPREHENSIVE MATERNAL AND CHILD HEALTH EXPENSES

GENERAL AUTHORITY

SEC. 410. (a) The Secretary may, through an identifiable administrative unit within the Department of Health, Education, and Welfare, take such action as may be necessary to make available, in accordance with this part and subject to such regulations as the Secretary may prescribe, to insurance companies and other insurers and pools of insurance companies and other insurers reinsurance against the part of claims brought by any of their insureds which are comprehensive maternal and child health practices and arising out of medical malpractice which exceed $100,000.

(b) Reinsurance under subsection (a) shall be made available pursuant to contract, agreement, or any other arrangement, in consideration of such payment of a premium fee, or other charge as the Secretary finds necessary to cover anticipated claims and other costs of providing such reinsurance.

PAYMENT OF CLAIMS

SEC. 411. The Secretary shall establish the general method or methods by which proved and approved claims which are covered by reinsurance made available under this part may be adjusted and paid for.

USE OF EXISTING FACILITIES AND SERVICES

SEC. 412. In carrying out his responsibilities under this part, the Secretary may use—

(1) insurance companies and other insurers, insurance agents and brokers, and insurance adjustment organizations, as fiscal agents of the United States; and

(2) officers and employees of any executive agency (as defined in section 105 of title 5, United States Code) as the Secretary and the head of any such agency may from time to time agree upon, on a reimbursement or other basis.

RECOVERY OF PREMIUMS

SEC. 413. (a) The Secretary, in a suit brought in the appropriate United States district court, shall be entitled to recover from any insurer the amount of any unpaid premiums lawfully payable by such insurer to the Secretary.

(b) No action or proceeding shall be brought for the recovery of any premium due to the Secretary for reinsurance, or for the recovery of any premium paid to the Secretary in excess of the amount due to him, unless such action or proceeding shall have been brought within five years after the right accrued for which the claim is made, except that, where the insurer has made or filed with the Secretary a false or fraudulent annual statement, or other document with the intent to evade, in whole or in part, the payment of premiums, the claim shall not be deemed to have accrued until its discovery by the Secretary.

REPORTS AND AUDITS

SEC. 414. (a) As a condition to the receipt of reinsurance under this part, each insurer and pool of insurers which is reinsured under this part shall file with the Secretary—

(1) a copy of each annual statement (and any amendments to it) filed with the insurance authority of the State in which reinsurance under this part is effective; and

(2) information respecting—

(A) ~~actual~~ claims asserted by patients (or their legal representatives) against comprehensive maternal and child health practices which are insureds of the insurers,

(B) reports of adverse medical incidents filed by such insureds, and

(C) any other matter pertaining to medical malpractice insurance as the Board may determine is necessary for the effective administration of the reinsurance authorized in this part.

(b) The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purposes of investigation, audit, and examination to any books, documents, papers, and records of any insurer or pool reinsured under this part that are pertinent to reinsurance provided under this part. Such audit shall be conducted to the maximum extent feasible in cooperation with State insurance authorities.

Part C—Education and Training

AUTHORITY FOR GRANTS AND CONTRACTS

Sec. 420. (a) The Secretary may, upon application and upon such conditions as the Secretary may prescribe, make grants to and enter into contracts with public and nonprofit private entities for the following projects:

(1) Projects to promote the teaching of students in health professional schools respecting alternative methods of delivering medical care.

(2) Projects to promote the training within comprehensive maternal and child health practices of students of health professional schools and individuals in residency training programs in family medicine and general pediatrics. Priorities shall be given to projects

involving comprehensive maternal and child health practices serving medically underserved populations.

(3) Projects to promote and establish programs under which comprehensive maternal and child health practices serving special populations are provided support services by health professional schools, including telephone and other telecommunication consultations and visits by the faculties of such schools.

(4) Projects to promote programs for the training of individuals (including physicians) in the management of comprehensive maternal and child health practices and to provide consultation and technical assistance to comprehensive maternal and child health practices to assist them in the management of their practices.

(b) For payments under grants and contracts under this section, there are authorized to be appropriated $7,500,000 for the fiscal year ending September 30, 1978, $10,000,000 for the fiscal year ending September 30, 1979, and $12,500,000 for the fiscal year ending September 30, 1980.

NATIONAL HEALTH SERVICE CORPS

SEC. 421. (a) In the administration of the National Health Service Corps program (under section 329 of the Public Health Service Act) the Secretary shall give special consideration to applications for assignment of National

Health Service Corps personnel to practice in comprehensive maternal and child health practices (as defined in section 402 of this title).

(b) In the case of any individual—

(1) who has received a degree of doctor of medicine or doctor of osteopathy;

(2) who obtained (A) one or more loans from a loan fund established under part C of title VII of the Public Health Service Act, or (B) any other educational loan for his costs at a school of medicine or osteopathy; and

(3) who enters into an agreement with the Secretary to practice his profession (as a member of the National Health Service Corps or otherwise) for a period of at least two years in a comprehensive maternal and child health practice (as defined in section 402, providing covered professional services through a fee payment schedule defined under section 312 (a) (2) to a special population, the Secretary shall make payments in accordance with subsection (b), for and on behalf of that individual, on the principal of and interest on any loan of his described in paragraph (2) of this subsection which is outstanding on the date he begins the practice specified in the agreement described in paragraph (3) of this subsection.

(c) The payments described in subsection (a) shall be made by the Secretary as follows: Upon completion by the individual for whom the payments are to be made of each year of the practice specified in the agreement he entered into with the Secretary under subsection (a), the Secretary shall pay 12.5 per centum of the principal of, and the interest on, each loan of such individual described in subsection (a) which is outstanding on the date he began such practice, except that if such practice was in a comprehensive maternal and child health practice serving special populations the payment shall be 25 per centum of such principal and interest.

(d) Notwithstanding the requirement of completion of practice specified in subsection (b), the Secretary shall, on or before the due date thereof, pay any loan or loan installment which may fall due within the period of practice for which the borrower may receive payments under this section, upon the declaration of such borrower, at such times and in such manner as the Secretary may prescribe (and supported by such other evidence as the Secretary may reasonably require), that the borrower is then engaged as described by subsection (a), and that he will continue to be so engaged for the period required (in the absence of this subsection) to entitle him to have made the payments provided by this section for such period; except that not more than 85 per centum of the principal of any such loan shall be paid pursuant to this subsection.

(e) A borrower who fails to fulfill an agreement with the Secretary entered into under subsection (a) shall be liable to reimburse the Secretary for any payments made pursuant to subsection (b) or (c) in consideration of such agreement.

TITLE V—FINANCING THE NATIONAL HEALTH INSURANCE FOR MOTHERS AND CHILDREN PROGRAM

PART A—FUNDS FOR SUPPORT OF THE NATIONAL HEALTH INSURANCE FOR MOTHERS AND CHILDREN PROGRAM

AUTHORIZATION OF APPROPRIATIONS

SEC. 501. (a) In order to assure prompt payment for the administrative and other expenses incurred during the early months of the program established by this Act, and in order to provide a contingency reserve, there is authorized to be appropriated, out of any moneys in the Treasury not otherwise appropriated, to remain available through a period of three years beginning with the date of enactment of this Act such sums as may be necessary for repayable advances (without interest) to the Trust Fund created by section 411.

(b) There are hereby authorized to be appropriated to the Trust Fund created by section 411 in each fiscal year such funds, in addition to funds deposited in such fund pursuant to section 412, as may be required by the Secretary to carry out the purposes of this Act.

PAYROLL AND SELF-EMPLOYMENT TAXES

SEC. 502. (a) Section 3101 of the Internal Revenue Code of 1954 (relating to social security and medicare taxes on employees) is amended by adding at the end thereof the following new subsection:

"(e) NATIONAL HEALTH INSURANCE FOR MOTHERS AND CHILDREN.—In addition to the taxes imposed by the preceding subsections, there is hereby imposed on the income of every individual a tax equal to 0.10 percent of the wages (as defined in section 3121 (a) except that the limitation on the amount of wages subject the tax shall not apply) received by him with respect to employment (as defined in section 3121 (r))."

(b) Section 3111 of such Code (relating to social security and medicare taxes on employers) is amended by adding at the end thereof the following new subsection:

"(e) MATERNAL AND CHILD HEALTH CARE.—In addition to the taxes imposed by the preceding subsections, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to 0.10 percent of the wages (as defined in section 3121 (a) except that the limitation on the amount of wages subject the tax shall not apply) paid by him with respect to employment (as defined in section 3121(r)).".

(c) Section 3121 of such Code (containing definitions applicable to social security payroll taxes) is amended by adding at the end thereof the following new subsection:

"(r) Employment for Purposes of Maternal and Child Health Care Tax.—For the purposes of sections 3101(c) and 3111(c), the term 'employment' has the meaning set forth in subsection (b) of this section except that—

"(1) the exclusions contained in the following paragraphs of subsection (b) shall not be applied—

"(A) paragraph (1) (relating to foreign agricultural workers);

"(B) paragraphs (5) and (6) (relating to employment by the United States or its instrumentalities) other than paragraph (6)(C)(iii) through (v) (relating to certain minor employments);

"(C) paragraph (7) (relating to employment by States and their political subdivisions and instrumentalities) other than paragraph (7)(C)(i) through (iv) (relating to certain minor employments by the District of Columbia);

"(D) paragraph (8) (relating to employment by charitable and similar organizations);

"(E) paragraph (9) (relating to employment covered by the railroad retirement system); and

"(F) paragraph (17) (relating to employment by subversive organizations); and

"(2) subsection (m) of this section (including services by members of the uniformed services in the term 'employment') shall not be applied.".

(d) Section 1401 of such Code (imposing social security addition to the taxes imposed by the preceding subsections, and medicare taxes on self-employed individuals) is amended by adding at the end thereof the following new subsection:

"(c) MATERNAL AND CHILD HEALTH CARE.—In there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to 0.10 percent of the amount of the self-employment income for such taxable year.".

TECHNICAL AND CONFORMING AMENDMENTS

SEC. 503. Section 218 of the Social Security Act (42 U.S.C. 418) (relating to agreements for the coverage of services performed in the employ of States and their political subdivisions and instrumentalities) is amended—

(1) by inserting in subsection (e)(1)(A) "subsections (a) and (b) of" immediately before "sections 3101 and 3111";

(2) by inserting in subsection (e) (2) (B) "subsections (a) and (b) of" immediately before "section 3111"; and

(3) by adding at the end of subsection (e) the following new paragraph:

"(3) Notwithstanding the provisions of any agreement entered into under this section, no State shall be under any obligation to pay to the Secretary of the Treasury, with respect to service covered under the agreement and performed on or after the effective date of section 402 (d) of the Maternal and Child Health Care Act, amounts equivalent to the taxes which would be imposed by sections 3101 (c) and 3111 (c) of the Internal Revenue Code of 1954 if such service constituted employment as defined in section 3121 (b) or section 3121 (r) of such Code.".

PART B—MATERNAL AND CHILD HEALTH TRUST FUND

CREATION OF THE TRUST FUND

SEC. 511. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the Maternal and Child Health Trust Fund (hereinafter in this part referred to as the "Trust Fund").

(b) The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 412 (c), and such amounts as may be appropriated to or deposited in such fund as provided in this part.

FUNDING OF TRUST FUND

SEC. 512. (a) There are hereby appropriated to the Trust Fund for the fiscal year ending September 30, 1976, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1) the taxes imposed by section 3101 (c) and 3111 (c) of the Internal Revenue Code of 1954 with respect to wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of such Code on and after the effective date of section 402 (a) of the Maternal and Child Health Care Act, as determined by the Secretary of the Treasury by applying the applicable rates of tax under such sections to such wages, which wages shall be certified by the Secretary of Health, Education, and Welfare in accordance with such reports; and

(2) the taxes imposed by section 1401 (c) of the Internal Revenue Code of 1954 with respect to self-employment income reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code on and after the effective date of section 402 (d) of the Maternal and Child Health Care Act, as

determined by the Secretary of the Treasury by applying the applicable rate of tax under such section to such self-employment income, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of records of self-employment established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns.

(b) The amounts appropriated by subsection (a) shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in subsection (a), paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such subsection.

(c) The Managing Trustee of the Trust Fund is authorized to accept on behalf of the United States, and deposit into the Trust Fund, money, gifts, and bequests made unconditionally to the Trust Fund or to the Department of Health, Education, and Welfare, or any part or officer thereof, for the benefit of such Fund or any activity financed through such Fund.

MANAGEMENT OF TRUST FUND

SEC. 513. (a) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this part referred to as the "Board of Trustees") composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, all ex officio.

(b) The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (in this part being referred to as the "Managing Trustee"). The Commissioner of the Social Security shall serve as the Secretary of the Board of Trustees.

(c) The Board of Trustees shall meet not less frequently than once each calendar year.

(d) It shall be the duty of the Board of Trustees to—

(1) hold the Trust Fund;

(2) submit to the Congress not later than the first day of April of each year a report, to be printed as a House document of the session of the Congress to which the report is made, on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next two fiscal years, which report shall include—

(A) a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year;

(B) an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next two fiscal years; and

(C) a statement of the actuarial status of the Trust Fund; and

(3) report immediately to the Congress whenever the Board of Trustees is of the opinion that the amount of the Trust Fund is unduly small; and

(4) review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

INVESTMENT OF FUNDS FOR THE TRUST FUND

SEC. 514. (a) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals.

(b) (1) Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States.

(2) For such purpose such obligations may be acquired

on original issue at the issue price, or by purchase of outstanding obligations at the market price.

(c) (1) The purposes for which obligations of the United States may be issued under the Second Liberty Bond Act are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund.

(2) Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of four years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield.

(d) The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

(e) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(f) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

ADJUSTMENT OF TRUST FUND FOR OVERPAYMENTS AND UNDERPAYMENTS

SEC. 515. (a) (1) The Managing Trustee shall pay from time to time from the Trust Fund into the Treasury the amount estimated by him as taxes imposed under section 3101 (c) of the Internal Revenue Code of 1954 which are subject to refund under section 6413 (c) of such Code with respect to wages paid on or after January 1 of the year following the date of enactment of this Act.

(2) Such taxes shall be determined on the basis of the records of wages established and maintained by the Secretary in accordance with the wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, and the Secretary shall

furnish the Managing Trustee such information as may be required by the Managing Trustee for such purpose.

(3) The payments by the Managing Trustee shall be covered into the Treasury as repayments to the account for refunding internal revenue collections.

(b) Repayments made under subsection (a) shall not be available for expenditures but shall be carried to the surplus fund of the Treasury. If it subsequently appears that the estimates under such paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Managing Trustee in future payments.

PAYMENT OF SERVICES AND ADMINISTRATIVE EXPENSES

SEC. 516. The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary certifies are necessary to make the payments provided for by title III of this Act and to make payments for administrative and research expenses incurred under this Act.

TITLE VI—PENALTIES, EFFECTIVE DATES, AND TECHNICAL AMENDMENTS

PENALTIES

SEC. 601. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact—

(A) in any request for payment under this Act,

(B) for use in determining eligibility for any benefit under this Act,

(C) for use in determining the qualifications of an institution, under section 202 to have payments made under this Act for such institution's furnishing of services, or

(2) knowingly and with fraudulent intent conceals or fails to disclose a material fact—

(A) in any request for payment under this Act,

(B) for use in determining eligibility for any benefit under this Act,

(C) for use in determining the qualifications of an institution, under section 202, in order to have payments made under this Act for such institution's furnishing of services; or

(3) having made application to, and received, any such benefit or payment for the use and benefit of another, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

(b) Whoever furnishes or dispenses a covered service to an individual for which payment may be made under this Act and who solicits, offers, or receives any—

(1) kickback or bribe in connection with the furnishing or dispensing of such service or the making or receipt of such payment, or

(2) rebate of any fee or charge for referring any such individual to another person for the furnishing or dispensing of such service,

shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

EFFECTIVE DATES

SEC. 602. (a) Except as provided in subsections (b), (c), (d), and (e), the provisions of this Act shall take effect on the date of enactment of this Act.

(b) Sections 402(a), 402(b), 402(d), and 412(a) (relating to collection of maternal and child health care taxes) shall take effect on January 1 of the year following the date of enactment of this Act.

(c) Part B of title II (relating to children's benefits) shall take effect on the following dates for children of the following ages on those dates—

(1) two years after the date of enactment of this Act for children below the age of seven years;

(2) three years after the date of enactment of this Act for children below the age of thirteen years; and

(3) four years after the date of enactment of this Act for all children eligible under this Act.

(d) Part C of title II (relating to maternity benefits) shall take effect two years after the date of enactment of this Act.

(e) Part D of title II (relating to special population benefits) shall take effect on the effective date, specified in subsection (c) or (d) of this section, for the furnishing of covered services to which covered support services under such part are related.

CONFORMING AMENDMENTS

SEC. 603. (a) Title V of the Social Security Act is amended by adding at the end thereof the following new section:

"PAYMENTS FOR SERVICES UNDER NATIONAL HEALTH INSURANCE FOR MOTHERS AND CHILDREN ACT

"SEC. 517. No payment may be made under this title for the furnishing of services which would be eligible for payment as a covered service under the Maternal and Child Health Care Act.".

(b) Section 1862 of the Social Security Act (42 U.S.C. 1395y) is amended by adding immediately after subsection (d) the following new subsection:

"(e) No payment may be made under this title for the furnishing of services which would be eligible for payment as a covered service under the Maternal and Child Health Care Act.".

(c) Title XIX of the Social Security Act is amended by adding at the end thereof the following new section:

"PAYMENTS FOR SERVICES UNDER THE NATIONAL HEALTH INSURANCE FOR MOTHERS AND CHILDREN ACT

"SEC. 1911. No payment may be made under this title for the furnishing of services which would be eligible for payment as a covered service under the Maternal and Child Health Care Act.".

Mr. Scheuer. Before we get to the witnesses. I am delighted to turn the program over to Senator Javits for his comments.

Senator Javits. Thank you. Mr. Chairman.

First, let me say that I am joining with Representatives Scheuer, who initiated this bill in the House, and I think he is entitled to full credit for having done so. Others, of us have worked on issues of national health coverage, national health scheme or insurance, however you would call it, but he was the first as far as I know to seek the phase-in with mothers and children and I think it is eminently sound, as I will explain in a moment. Hence, I have joined myself in introducing the bill in the Senate together with Senators Brooke and Cranston who are similarly interested.

I might say that I am the ranking member of the committee which is the Labor and Public Welfare Committee which in the Senate is in great measure responsible for this kind of health problem and in it we have the Health Subcommittee of which Senator Kennedy is chairman. In the House it is being handled by Paul Rogers, chairman of the Subcommittee on Health and the Environment. I am very grateful to Congressman Rogers, with whom I work very closely, to have designated the author of the bill, Congressman Scheuer, to conduct and preside at these hearings.

To me, and I will not duplicate the fine statement made by my colleague, two things are essential. One, the cooperation of the health care fraternity, and I am very grateful to the witnesses who have appeared and will appear in New York this morning. Of course I know Dr. Pomrinse and his colleagues very well and I am delighted that they are the leadoff witnesses.

It is my judgment that the idea of phasing in national health coverage through the Mothers and Children's Act is an idea whose time has come. It is to take another step toward a major national goal of comprehensive health care for all Americans. As Congressman Scheuer has said, Medicaid and Medicare have provided health care coverage for the elderly and many of the poor but we should now provide as a next step for mothers and children a proper thesis of concepts in that area and go on from there.

I might point out that we have also experimented with health maintenance organizations, which have begun to be established around the country with Federal aid, and also with other group practice units which we are giving special Federal support to under the pending bill. Now I continue to support the enactment into law of a national health measure. I recognize the political and fiscal realities, however, and therefore the phased approach, going now to mothers and children, I think is extremely advisable and desirable. It makes enormously good sense to me and to my colleagues in the Senate, who have joined in this bill, both in human terms and as national policy in terms of ultimate national health coverage. The comprehensive care which is here contemplated is not only sickness care but we are thinking about health care.

It is imperative to safeguard the health of mothers and children by providing accessible comprehensive health services. At the same time both the financial and organizational provisions of this legislation allow us to set in motion and to evaluate in a more limited area health systems and cost controls and to determine what is the most rational way of delivering sickness and health care of high quality and how it may be provided universally.

While we provide the means of increasing access of mothers and children to health care, it emphasizes that the preventions of illness and the promotion of health are our ultimate responsibility. And, we will have an opportunity, if we adopt this measure; to test and to prove out those concepts of national health coverage in terms of feasibility and desirability which many of us sponsor. Also, we can foster through this measure important improvements in quality and cost effectiveness of the total health care system.

Now this is not any personal idea of mine, it is Congressman Scheuer's, but I join in it fully. Also, I have met personally with the department chairmen of pediatrics, and obstetrics and gynecology of all New York's medical schools and they have in turn been in touch with other leaders in the professional and academic communities. All these experts have been most generous in sharing their expertise and suggestions to improve this bill. I acknowledge their help and thank them on behalf of the people of our State for their cooperation and I will read, when I am through, some brief comments from medical authorities in the country on this bill which have been contemporaneously obtained.

Today's hearing will assist Congressman Scheuer and me, and our colleagues, to strengthen and improve the legislation and at the same time to put national health coverage definitely and strongly on the priority agenda for national policy. And, in this regard, I wish to reject the stereotypes generally advanced under the rubric of national health insurance. I am not considering socialized medicine nor are my colleagues but on the contrary enhancement of the private doctor-patient relationship, the opportunity for the use of all the private sector now in being, like Blue Cross, Blue Shield, Group Practice and health insurance enterprises and fair compensation to providers and payers for services as to the expense factor.

We are already dealing with a $100 billion business where costs have escalated at twice the rate of inflation and more. We can only do better, not worse, on costs with national health coverage. I would like to close on this as follows.

While I was a child growing up in New York City, the state of health for the young was dismal. Infant mortality was shockingly high, and, as Congressman Scheuer has pointed out, it still is compared to other countries in the world, including most of the industrialized countries. Infectious diseases were dread killers, and the profession of pediatrics itself was in its infancy. I might say that I patronized a doctor who charged fifty cents a visit and whom, when I had a sore throat—and I had many—was in dread fear of my getting what now we would call a strep throat and dying because there was no way to stop it at that time.

Throughout my professional lifetime I have seen our society take many important steps forward in medical knowledge and in the transmuting of that knowledge into medical care, yet we know that many groups, particularly the disadvantaged, who are at greatest risk simply cannot afford the health care they need. So far it still is money largely that determines how soon you die and how long a life you may have and how happy one is in physical terms. We also know that the quality of health care can and must be improved for all. We can be proud of our progress but we cannot be indifferent to the distance that is still to go.

Now, I would like to read very briefly some of these comments, they are all available. They are geographically spread.

Harold Schulman, Professor and Chairman of the Department of Gynecology and Obstetrics at the Albert Einstein College of Medicine said in speaking of this bill:

> The proposal is a noble and necessary goal. I wish you much luck and success in this venture. A country must invest in its young to insure that they are born with their mental and physical capacities intact.

Leon I. Mann, professor and cochairman, department of obstetrics and gynecology, school of medicine, State University of New York at Stony Brook:

> I most certainly agree that our national priorities for health policy must be concerned first and foremost with the quality of care for our pregnant women and children. Our present health care delivery system and insurance program could be significantly improved, and careful planning on a national level by the Federal Government with proper emphasis on rural and urban needs is clearly indicated in my opinion.

John H. Knowles, whom we all know so well, president, the Rockefeller Foundation:

> This is an area of obvious need and deserves the attention that you are giving it. I am particularly pleased to see the emphasis on prevention and health education.

By the way, both of these are included in the bill.

Howard H. Hiatt, dean, Harvard School of Public Health:

> My overall reaction is strongly positive. The bill could represent an important first step toward full implementation of comprehensive health insurance for the Nation. I am pleased that you are proceeding to attack this set of problems that is of such importance to our people and has been of such concern to you.

Finally, Walter J. McNerney, president, Blue Cross Association:

> In the Blue Cross organization we share your deep concern for phasing in National Health Insurance and learning as we go. We are interested in your proposed legislation and welcome the opportunity to assist you.

Congressman Scheuer, I think this is a great tribute to you as well as to the bill and I am very pleased to read these statements.

Mr. SCHEUER. Thank you, Senator. If there are any that you didn't read, the entire group of statements will be put into the record.

[The material referred to follows:]

COMMENTS ON "NATIONAL HEALTH INSURANCE FOR MOTHERS AND CHILDREN ACT"

Allan C. Barnes, M.D., Vice President, The Rockefeller Foundation: "I think the objective of your legislation is excellent and starting with the identifiable segments of the population—mothers and children—is an appropriate way to proceed."

Raymond L. Vande Wiele, M.D., Chairman, Department of Obstetrics and Gynecology, College of Physicians and Surgeons of Columbia University: "I want to congratulate you for your foresight in sponsoring this bill which should make it possible to extend to all mothers and children the benefits of a type of medical care that is available now only to a small fraction of the population."

Charles D. Cook, M.D., Professor and Chairman, Department of Pediatrics, Downstate Medical Center, State University of New York: "Your proposal is interesting and exciting to those of us in Pediatrics. I and other pediatricians, I'm sure, would be delighted to help in any way we can with the furtherance of this most crucial and important legislation."

Harold Schulman, M.D., Professor and Chairman, Department of Gynecology and Obstetrics, Albert Einstein College of Medicine: "The proposal is a noble and necessary goal. I wish you much luck and success in this venture. A country must invest in its young to insure that they are born with their mental and physical capacities intact."

Robert E. Cooke, M.D., Vice Chancellor, and George I. Lythcott, M.D., Associate Vice Chancellor, Center for Health Sciences, University of Wisconsin: "We applaud your thoughtful and aggressive approach to the problems of maternal and child health. We support S. 3592 in its general context as laudable, thoughtful and comprehensive. We hope that it will meet with substantial support from your peers."

Jean Pakter, M.D., Director, Bureau of Maternity Services and Family Planning, New York City Department of Health: "I believe that your proposal has great significance and represents an outstanding contribution to maternal and child health. On behalf of mothers and children, warmest thanks for a giant step forward. Good luck in this endeavor."

Vincent P. Dole, M.D., Professor and Senior Physician to the Hospital, The Rockefeller University: "I welcome your leadership in the development of much-needed programs for comprehensive health care, and am impressed with the thoroughness with which you have explored this complex problem."

Fritz Fuchs, M.D., Obstetrician and Gynecologist-in-Chief, The New York Hospital—Cornell Medical Center: "Your proposal has a great appeal to an obstetrician who feels very strongly that mothers and newborn infants have been grossly neglected by the current health insurance systems."

Carleton B. Chapman, M.D., President, The Commonwealth Fund: "I am entirely in favor of the gradualist approach to comprehensive national health insurance embodied in your bill. After Medicare a maternal and child health provision is logical and very right."

Leon I. Mann, M.D., Professor and Cochairman, Department of Obstetrics and Gynecology School of Medicine State University of New York at Stony Brook: "I most certainly agree that our national priorities for health policy must be concerned first and foremost with the quality of care for our pregnant women and children. Our present health care delivery system and insurance program could be significantly improved and careful planning on a national level by the federal government with proper emphasis on rural and urban needs is clearly indicated in my opinion."

Frank A. Oski, M.D., Professor and Chairman, Department of Pediatrics State University of New York, Upstate Medical Center: "Your bill represents landmark legislation which is badly needed."

Odin W. Anderson, Ph.D., Professor and Director, Center for Health Administration Studies, University of Chicago: "What I believe is commendable and judicious about the bill is that for a change national health insurance is being formulated with reference to the targeting of problems in some segments of the population."

Max H. Schoen, DDS, Chairman, Section on Public Health and Preventive Dentistry, School of Dentistry UCLA Center for Health Sciences: "I think the compromise is necessary, this specific segment is a good one to add first."

Solan Chao, M.D., Associate Clinical Professor, College of Psysicians and Surgeons of Columbia University: "I personally believe that from the standpoint of the needs of our citizens this legislation is past due but nonetheless welcome."

John H. Knowles, M.D., President, The Rockefeller Foundation: "This is an area of obvious need and deserves the attention that you are giving it. I am particularly pleased to see the emphasis on prevention and health education."

Philip R. Lee, M.D., Professor of Social Medicine, School of Medicine, Health Policy Program, University of California, San Francisco: "I believe that this is a very important step forward and that the bill addresses itself to one of our highest priority needs in terms of medical care."

Ruth Watson Lubic, General Director, Maternity Center Association: "We are delighted that you recognize the importance of maternal and child health as the building block for the well-being of our citizenry."

Elliot F. Ellis, M.D., Professor and Chairman, Department of Pediatrics, School of Medicine, State University of New York at Buffalo: "Your interest and support of the health of children and mothers is appreciated by all of our faculty."

Howard H. Hiatt, Dean, Harvard School of Public Health: "My overall reaction is strongly positive. The bill could represent an important first step toward full implementation of comprehensive health insurance for the nation. I am pleased that you are proceeding ot attack this set of problems that is of such importance to our people and has been of such concern to you."

J. George Moore, M.D., President, American Board of Obstetrics and Gynecology: "I wish to appraise you of the complete support of the physicians who deal with medical problems of mothers and children for your proposed legislation."

J. Warren Perry, Dean, School of Health Related Professions, State University of New York at Buffalo: "The provisions of this bill, by assuring payment for preventive maternal and pediatric services, address a significant factor in maintaining the health of the nation's population. Many critical social problems arise from illnesses which could be either minimized or prevented altogether if proper and timely care were obtainable."

Walter J. McNerney, President, Blue Cross Association: "In the Blue Cross organization we share your deep concern for phasing in National Health Insurance and learning as we go. We are interested in your proposed legislation and welcome the opportunity to assist you."

Mr. SCHEUER. Now it is our pleasure to hear from Dr. S David Pomrinse, executive vice president, the Mount Sinai Hospital, accompanied by Dr. Kurt Deuschle, chairman, department of community medicine, Mount Sinai School of Medicine, and with them is Mrs. Pat Ingram who will also testify.

Gentlemen, you can either read your testimony or you can sum up your testimony, it will be printed in full in the record. Then we will probably have some questions to ask of you. I would hope that even while you are giving your testimony—Senator, if you feel like interrupting and asking a question, there are only two of us here and I would think we could manage very informally to have some give and take even as the testimony is heard. So at your own discretion you can summarize and then we can have some give and take or you may read your testimony.

STATEMENT OF S. DAVID POMRINSE, M.D., EXECUTIVE VICE PRESIDENT, THE MOUNT SINAI HOSPITAL; KURT W. DEUSCHLE, M.D., THE ETHEL H. WISE PROFESSOR AND CHAIRMAN, DEPARTMENT OF COMMUNITY MEDICINE, THE MOUNT SINAI SCHOOL OF MEDICINE, CITY UNIVERSITY OF NEW YORK; AND PAT INGRAM, NEW YORK, N.Y.

Dr. POMRINSE. Thank you, sir.

Let me just follow through the testimony summarizing it as I go and then you can expand it as you like.

I initiated the drafting of this by referring to experience I had when I was in the U.S. Public Health Service in the late 1950's which led up to the introduction of the McNamara bill in the Senate in 1960 which was defeated; it was 5 years too early. It eventually ended up as medicare as you know. We had a lot of discussions then as to what we should go for, what piece of national health insurance, because we were all interested in approaching it and an incremental basis made the most sense. I was fortunate in being the U.S. Public Health Service representative working with the Social Security Administration at that time in laying the groundwork of what later became medicare.

We all knew that the way to approach this medically from the standpoint of the biggest bang for the buck was to cover the mothers and children first. We also knew that it didn't make much political sense in those days because the urgent demand was for financial health for the older people whose individual medical needs were enormously expensive and who simply could not handle it. This was before medicaid and medicare and people on social security simply could not get the basic coverage that they needed. The social/political decision was to move with medicare first for the aged.

Mr. Scheuer. That may have been a proper policy at the time. Undoubtedly there was an agonizing need among the elderly for health services which they could not afford and it does provide a tremendous allocation of health resources to that target group. We are spending now approximately $1.032 per senior citizen over the age of 65. We are spending now approximately $382 for the 18-to-65 group and we are spending less than $200 per capita for children under 18. So whereas we were right in providing for health care for senior citizens which they could not even marginally begin to support, I think we are now faced with the reality that we have a lot of catching up to do in the area of health services for children.

Dr. Pomrinse. Of course children tend to be healthier than older people and they don't need as much but they do need some and they need preventive services and that is what has been missing. Indeed I think one should look at preventive services as a method of prevention. You put a couple bucks in and you hope to get much more back. We know a good deal about how to prevent illness and disability in children.

You mentioned polio and rubella. These all came out of pediatrics. The improvement of prenatal care has certainly led to the improvement of the health of the children who are born and the prevention of death of the mothers. We have tried to use this in adults and it has not worked out that well. We don't know enough yet how to prevent illness and disability in older people but we certainly do in children and this is where we ought to apply what we know. There is not any medical risk in this, there is not any gamble that we know it will work—we know it will. It is simply a matter of making sure that everybody gets his shots and the medicines and the nutritional programs that they should get.

I am concerned at the absence from the bill of one additional benefit which probably would not cost very much and would have an enormous payoff and this is family planning. I wish to address the concerns about the fact that the unwanted child adds greatly to the medical and social costs in the country. The best prevention in that sense is that the baby has been wanted and not unwanted. Often these youngsters are born to adolescent girls who can barely take care of themselves let alone assume responsibility for a child, and when they are born to youngsters they more frequently tend to be premature, have birth defects and suffer from a less than optimal upbringing by their very young mothers. Psychological problems are compounded and they don't get the nutritional and medical needs that they should have.

So I would urge the consideration of the addition of the family planning services as an integral part of the sort of things that obstetricians do anyway and that go along with the natural pattern of care delivery in this sense.

Senator Javits. Doctor, if you don't mind an interruption here because we are deeply concerned with that on my committee, wouldn't that duplicate existing family planning programs which the Federal Government already assists?

Dr. POMRINSE. Obviously medicaid would be duplicated but this bill is addressed to the needs of all people with the essential disregard of their economic level.

Senator JAVITS. It is not only medicaid where we have family planning services. We have family planning services in the poverty program.

Dr. POMRINSE. Right. I am talking about everybody. This is a bill addressed to everybody without regard to determination of need except in one area which I will come to in a minute.

Senator JAVITS. Would you merge the other program into this one?

Dr. POMRINSE. Yes. As a matter of fact, one of the things I have not said in the testimony is that there are enormous cost offsets in this which I assume have been calculated in terms of relieving medicaid and the other special programs and incorporating them into one generic bill. I would think this would automatically have enormous administrative and direct service cost benefits.

Mr. SCHEUER. Yes. The price tag we have put on this bill annually is about $11 billion but most of that is not new money. Most of that is money that we are spending now far less cost effectively in other programs. New moneys may amount to $2 or $3 billion, but most important we would gain a tremendous cost benefit advantage in terms of extending excellence of health care to people who are not getting it now, the mothers and kids who are not getting it now. We are aiming those dollars not at tertiary hospital beds and not at scanners—in other words, it is not sickness care, it is preventive care at the early end to avoid sickness in the community. Virtually all of it is on an outpatient basis which is inexpensive and very cost effective. I think that is one of the things that intrigues me and the Senator about this whole preventive approach. You get a tremendous bang for the buck and that is the way this bill has been designed.

Dr. POMRINSE. There is one plea I would make and that is that the management of the program, the administration of it, be intimately linked to medicare. We deal constantly with floods of paper. Sometimes we think the hospitals are a paper factory as we generate all the various forms and reports. I am not speaking so much of the medical information as the administrative information which has to go to the various places.

To the extent that the same carriers are used I think you would have a far greater opportunity for simplification of the administration. To the extent that the same utilization review programs, and they are bound to come up as this program gets underway, as this program goes on—that we mechanize identically as conceivably is possible to that quality control, retrospective medical audits and so on and all be intimately not only linked with but made identical with so that the only difference is the code number on the piece of paper but that the format of it be the same.

The clerk has to learn two different ways of filling out a report form. It is two different clerks because otherwise they get them confused. If we want to save money, there are enormous amounts of money to be saved. Third party. For example, in our out-patient department people have their care paid for by multitudinous services. We have a unit of six clerks who bring in collections three times their aggregate salaries. Obviously I have to do it because if we didn't complete those bills I would lose the three times but that is a ridiculously inefficient way to collect money. They should bring in at least 100 times their salaries but because of the tedious nature of splitting bills between third party payers I would urge you to make things as identical and as clean as possible.

The copayment for the clinical services that are not preventive hits me as being either too much or too little. If it is to act as a hesitation fee, it is too small to be very effective and it costs too much to determine whether or not that patient comes under your special covered population group. Therefore, if you are going to provide the program, the 10 percent is not going to do much of anything, I don't think. Overutilization of pediatric services in children I believe has not been documented. I have not seen any references to this except in pediatric surgery and that would not be affected by this except for tonsils and adenoids, for example.

Mr. SCHEUER. We do have a provision for a second medical opinion for certain surgical procedures.

Dr. POMRINSE. But in the pediatric medical services this specifically calls for a 10-percent coinsurance.

Mr. SCHEUER. Yes.

Dr. POMRINSE. I don't think that is going to stop all mothers except for those who would come under the poverty line and exempted from it. Just think of the time it takes to determine whether or not somebody arrives at the poverty line and is $3 above or below $3 and in a large institution this becomes a major administrative chore. I am convinced that the cost of doing that would be greater than the 10 percent that one has to collect for various places.

Mr. SCHEUER. We are faced with a condition and not a theory. The condition is that as a matter of political acceptability many groups feel there has to be some disincentive for frivolous use of the system, for burdening the system with nonsensical stresses which provides a very illogical kind of rationing of already scarce health services because once you provide a national health system for anybody and provide the funding you have an almost limitless demand.

You create that demand ipso facto when you create the funding. How do you regulate it? How do you apportion it? How do you limit it?

I am not sure that this is the right system. I don't think Senator Javits is any more positive about it than I am. We are sort of groping in the dark. How do you limit this? Do you have any suggestions as to a better mechanism for doing that?

Dr. POMRINSE. I think if you use the coinsurance.

Mr. SCHEUER. That is on the horns of a dilemma, too. You want to have some kind of a little slap on the wrist to make the cost real, to deter the frivolous use, but you don't want to have it so high that the woman is not going to bring the child in when it is sniffling and has a fever and it ought to be brought into that neighborhood clinic. That is a dilemma.

Dr. POMRINSE. The only course I can think of is have an increasing hesitation fee—nothing the first visit, 10 percent the second, 20 percent the third unless the doctor specifically demonstrates that this is something where a child has to be brought in frequently such as an allergy or a rehabilitation program with a medical necessity to speak for itself. I agree with you it is a very tough problem. I don't think it gets anywhere though. This does neither. It neither opens the door to everybody and yet it compounds the administrative cost to the place where it is silly.

Mr. SCHEUER. It accomplishes very little.

Dr. POMRINSE. Yes. You are talking about a $10 visit with a $1 coinsurance. It will cost me $3 or $4 to get that determination made and it just simply takes time and people.

In the determination of prospective payment for institutional care, we have no problem with that. We are used to it in New York, we have been living with it for 6 years. We have problems with it but we have no problem with the concept. We have a problem with the techniques. I recognize that the Secretary has a choice of methods in the bill. I wonder whether it would be useful to delegate that to those States which have ongoing prospective payment programs which meet Federal standards. This is one of those things where you might well have State administration, and they are increasing them each year, that have better and better programs.

We are learning our way through this, but there are States such as Rhode Island, Maryland, and many others besides New York that have staffs at the State Department level that seem to know what they are doing, and they are getting better at it each year as they get more experience. To try to have one countrywide system, I think we may well end up in disaster. The only way that the New York system is able to function at all over the years has been because there are enough hospitals so that you can run groupings by size and so on and still address individual variances through what we call the appeal mechanism where you can get individual attention if you have a reason for it, but it is in concept at least a prospective system and it works. It works from the standpoint of controlling costs.

Let me divert for just a second since I have such a distinguished audience. You may or may not be familiar with the report that was commissioned by the Social Security Administration, the Dowling report which demonstrated that New York—and this is downstate New York compared to New York City—with four other large cities (Chicago, Philadelphia, Detroit, and Cleveland) I think compared the rate of escalation of hospital costs in the last 5 years and New York's inflation rate corrected for the general inflation—only general inflation—was two-thirds of the remaining comparative cities and New York has inflated 2 percent more than inflation. In other words, we are not double but 2 percent ahead per year of the rest of the country.

Excuse me. Let me say that again. We have inflated two percent faster than the general inflation rate each year over the last 5 years, which considering all of the technology and the fancy care institutions in New York desperately trying to keep up we think is an outstanding accomplishment.

Mr. SCHEUER. Excuse me. If nationally the costs of medical care are inflating at twice the rate as the consumer price index is inflated, where does that come from?

Dr. POMRINSE. It comes from the fact that the rest of the country is going a lot faster than New York State and New York City in particular.

Senator JAVITS. Is this the Dowling report?

Dr. POMRINSE. This is the Dowling report, professor at the University of Washington. It was filed with the Social Security Administration and there are informal drafts of it all over the place. It was not formally published.

Senator JAVITS. I think it is very useful.

Mr. SCHEUER. Are you implying that the medical profession is more adept outside of New York State of manipulating the system than our own fine doctors in this State?

Dr. POMRINSE. Obviously I would not use that term because this is a matter of hospital cost inflation.

Mr. SCHEUER. I see.

Dr. POMRINSE. What I would say is that physicians outside of New York State have been more successful in bringing pressure on their administrators and boards of trustees in getting the latest gadget and getting better staffing and so on than we have and this in spite, as you know, of the very rapid inflation in hospital employee salaries in New York as the result of unionization and a whole lot of other things that we could divert into.

Senator JAVITS. So you give it a positive—I don't know whether you have misspoken yourself. You said a minute ago, if I understood you correctly, that they are giving better medical care because the cost increase is higher.

Dr. POMRINSE. What I said was they were getting more gadgets. I didn't say the medical care was better.

Senator JAVITS. I think that is very important. Are you telling us that we have been better to be restrained and that our medical care is roughly comparable? It does not have to be exact in every department and that therefore we are getting more for the consumer's dollar than other jurisdictions.

Dr. POMRINSE. There is no question that when you squeeze a system, any system, you get some fat out. There is a point beyond which you begin to squeeze too hard and you get reduced service delivery.

There is one suggestion in the Dowling report that may indicate that New York perhaps has gone too far. Let me quote it. Around the country the Joint Commission on Accreditation puts on probation or disapproves about 5 percent of the hospitals. Their rule of thumb, they are going to lop off about 5 percent. In the last year in New York City 17 percent of the hospitals have been either put on probation or disaccredited, and there are a number of reasons for that. It is just conceivable that we have gone too far in squeezing the system. We don't know this. It would take further information to determine it.

Mr. SCHEUER. We are spending about $1,000 per capita in New York City annually for health services. We have about a $7 billion health service bill for about 7 or 7½ million people. It seems to me this is an astronomical sum. Is the rest of the country actually spending more?

Dr. POMRINSE. No. I was talking about in-hospital rate inflation which is a measurable thing because we all report on a fairly common basis. The financial figure is roughtly $500 a person throughout the country for everything, the whole kit and caboodle. One obvious reason in New York is that the salaries of people working in the health field is 50 percent higher than it is anywhere else. Our union arbitrator is supposed to come out with a decision shortly.

In the recent hospital strike the minimum for a unionized employee was $5 an hour plus $1 in fringe benefits. You go across the river to New Jersey and it is $3.50 or thereabouts and far less in fringe benefits. That immediately translates itself. You are going to have so many nurses and so many floor sweepers and so on in a figure that is pretty close. Now part of the rapid inflation in the rest of the country is the catching up. We moved ahead first and now we are tending to be slowing down but perhaps I can come back having, I hope, made my point about the rate review.

I would like to talk a little bit about title IV of H.R. 14497 which is aimed at prepaid group practices for maternal and child health services. I support prepaid group practice. I have no problem with that. I have a terrible problem with a limited prepaid group which consists only of obstetricians and pediatricians because I don't understand how they can work. This would mean that the mother who also had heart disease and could not go to one place, have her chart available, have the internist and the cardiologist come down the hall and see the mother at the same time the obstetrician was seeing her.

The very benefits of the interdisciplinary group practice, it seems, are destroyed when you begin to do it on a specialty basis. To make it even worse, almost all obstetricians are also gynecologists—that is the way they train and they see women at various stages of their health problems. So the obstetrician when he is functioning as an obstetrician is in the prepaid group, when he is functioning as a gynecologist as I understand it he would have to go off somewhere else and be seeing those patients on a fee for service basis even if it was under the same roof.

I therefore cannot support the concept of a specialized prepaid group. I have no problem with saying let prepaid groups offer these services under the capitation program. Given a large prepaid group I could see that as a very positive approach but I can't see it if the only services to be rendered are maternal and child services.

Senator JAVITS. I might say I am very sympathetic to that idea. We will examine it very carefully.

Dr. POMRINSE. Thank you, Senator.

Finally, the Advisory Council is certainly an excellent idea. The trouble I see with it is that the 10-person Advisory Council with a majority of nonproviders leaves 4 providers and you are dealing with pediatricians, obstetricians, all kinds of hospitals, free-standing clinics and hospital based clinics and how you are going to get 4 people who represent fairly those interests and be knowledgeable about all those interests seems to me too difficult. I would suggest enlarging the membership so that there could be better representation on difference concepts.

[Dr. Pomrinse's prepared statement follows:]

STATEMENT OF S. DAVID POMRINSE, M.D., EXECUTIVE VICE PRESIDENT, THE MOUNT SINAI HOSPITAL, NEW YORK CITY

I am Dr. S. David Pomrinse and I am Executive Vice President of The Mount Sinai Hospital in New York. I speak as one who has had considerable experience in the drafting of medical care legislation, having been the U.S. Public Health Service Representative in the preparation of the earliest Medicare bills in the late 1950's. At that time it was recognized that the greatest immediate need for financial assistance in the payment of medical care costs was for the aged. It was also clearly recognized then that while the social needs were greatest in the elderly, the preventive medicine needs were greatest in the young. It was clear that the investment of a given number of dollars would provide far greater long-term results in treating young people than in treating the elderly. As the debate went on, it became established public policy to deal with the social problem first and to re-address the problems of assuring preventive health services for children as the next phase in meeting the payment for services for the American people when the cost of these services exceeded the ability of large groups of the population to meet them and the value to the nation of providing them was great.

I believe the best way to look at this proposed program is not as a means of paying for medical care, but as a means of investing in the future health of the people of the United States. We have learned a great deal about how to prevent illness and disability from the pediatricians and the obstetricians and while there have been efforts to apply this concept to the adult population, those efforts have not borne great fruit to date. The payoff among mothers and children, however, is enormous. It may well be that even in times of fiscal crises, the national concern for the future health of the citizenry should sway the decision, even at the cost of major new Federal expenditures. The return on the investment will mean significantly reduced medical care expenditures for long-term disability, child welfare services and long-term care institutions in the decades to come.

While I recognize the need to limit benefits at some point and the tendency to continue to add benefits to the place where programs become impossibly expensive, I do believe that the program would be far better rounded if family planning services were added. If one seeks to apply the principles of prevention, it must be recognized that the unwanted child will add greatly to the medical and social costs in this country. Often born to adolescent girls, these infants more frequently than the rest of the population tend to be premature, have birth defects and suffer from a less than optimal upbringing by their very young mothers, many of whom indeed are unable to accept responsibility for themselves, let alone for a child. Psychological problems are compounded, and needed nutritional and medical services may not be obtained. The assurance that children who are born are indeed wanted would significantly improve this program and the health of the younger population of the country.

From the prospective of a provider, there is one plea I would make as urgently as I possibly can. That is that the administration of this program should be integrated with the administration of Medicare. No one has ever measured the cost to all who pay for medical care of duplicative programs, each with its own rules and procedures and each ignoring the others—with all of which the administrator of a hospital must deal. The multitudinous payment systems in themselves cost large amounts of money within the hospitals in order to complete various forms and to split bills among various third-party payers. In addition, each player has his own methods for claim review, each wanting different parts of the medical record and different analyses of medical information. The methods for ascertaining eligibility for benefits varies enormously from on-line computer terminals in a few instances to notices of admission which are lost (and therefore bills are disregarded) in others. Utilization review programs are repetitive and duplicative, each has its own limitations and rules, and all this adds up to significant additional cost in the total hospital bill. I was therefore pleased to see that the legislation calls for carriers for the administration of benefits and makes reference to simplified forms and procedures. However, unless identical forms are used and identical procedures and limitations applied, the administrative savings will not occur.

The requirement for co-payment for certain covered services strikes me as either too little or too much. While I have come to recognize that the use of the co-payment technique may help to discourage unnecessary or marginal medical care, the need to collect a 10 per cent co-payment from those who are judged not to be in need will require a determination of whether or not they would qualify as being needy and thus require another administrative procedure which would undoubtedly cost more than the 10 per cent co-payment involved. I do not believe that it is common for excess utilization to be demonstrated in children and I, therefore, would be biased in the direction of eliminating the co-payment entirely, since it probably involves very little money and a good deal of trouble. If it is felt that it is necessary to continue having the co-payment, I would raise it to 20 per cent in order that the cost of collection not be greater than the amount of money involved.

The Section that speaks to prospective payment for services by institutions is in line with current thinking. I would, however, carry it one step further. There are several different prospective systems currently in use in different states in this country. There are staffs of varying expertness in these states who have been reviewing hospital reports and arriving at reimbursement rates to be applied in the coming year. It would make no sense and would clearly add to administrative cost both for the Federal government and for the hospitals to have yet another system of calculating prospective reimbursement rates. I would urge, therefore, that the Secretary be mandated to review state programs for the development of prospective reimbursement rates and if he finds that a state has a program which would meet his standards for determining the reasonable cost of providing services on a prospective basis that the approve that agency for the setting of rates for this program as well as for any other programs which may come under the purview of that state program. In New York State for example, both Medicaid and Blue Cross rates are developed by or under the rules of the State Health Department. It would be simple enough to have the promulgated rates also include those services under this program and have the Secretary check periodically, perhaps on a sampling basis, to ascertain that the state has indeed followed the Federal rules and has also assured the hospitals that the method of calculation produced a reasonable cost-based rate. The Committee is urged to consider the delegation of rate calculation and promulgation to approved state agencies or rate review boards.

I address now Title IV of H.R. 14497, which is aimed at promoting the development of prepaid group practices for the provision of maternity and children services. I have no quarrel with the growth and development of prepaid group practice. I believe it is healthy and in the American spirit to have competitive organizational and financial patterns which can be tested against each other. I have, however, a problem with a limited prepaid group practice addressed only to mothers and children. I believe this tends to fragment the concept of the prepaid group and destroys the intimate interrelationships among physicians in different fields of care. The strongest and best groups in the country are those which have the broadest range of services and do not discriminate by age or any other medical criterion against patients in their programs. I could see this Title altered in such a way as to encourage the payment of services on a capitation basis to members of prepaid groups, but argue vigorously against the creation of this highly specialized and somewhat parochial form of care. For example, obstetricians are trained dually in obstetrics and in gynecology. Under this program, those physicians who participated in these specialized groups as obstetricians would not be eligible for prepaid payment of their services when they functioned as gynecologists. The creation of a unique form of practice should address the realities of the medical manpower involved as well as the needs of the patients and to expect a physician to practice as an obstetrician in a specialized prepaid group part of the time and perhaps in another physical location as a fee-for-service gynecologist is simply not in accord with either medical or socal behavior. In the comprehensive prepaid group practice of course, the obstetrician/gynecologist would see all of his patients on a prepaid basis under the same roof without the conflict suggested above.

Another example of problems with this concept is the involvement of specialists needed to supplement the care of the pediatricians. Often sub-specialists are necessary such as surgeons, urologists, neurologists, etc., and it is hardly likely that they would be members of a small specialized group practice. Experience has dictated that the most successful group practice is often the largest, has the greatest numbers of specialties represented, has the best administrative and business management practices, and is related to hospitals in such a way that the group benefits from reduced hospitalization. To violate this experience is to force history to be repeated again rather than to learn from it. I would urge that the provision for the limited prepaid group practice program envisioned in this bill be eliminated.

My final comment addresses itself to the Advisory Council. I applaud the concept and purposes of the Advisory Council, but consider only that it is too small in number of members. There would be only four providers on a ten-person council, which for a program of this complexity is simply too few. There are two major medical specialist groups involved, the pediatricians and the obstetricians, there are specialized hospitals and generalized hospitals, there are free-standing clinics and hospital-based clinics,-there are the representatives of fee-for-service medicine and the representatives of prepaid group practice, and there are the variety of carriers. It would be almost impossible to obtain adequate representation for these various interests by having only four providers on the Council. I would recommend that the number be expanded to 18 to 25 with a minority of seats available to the various provider group representatives.

Finally, I would like to express my gratitude to the Committee for the opportunity to present my views. With me is Dr. Kurt Deuschle, Chairman of the Department of Community Medicine at the Mount Sinai School of Medicine who has extensive experience in these problems as he has seen them in the East Harlem area of New York City.

Dr. POMRINSE. I would like to ask Dr. Kurt Deuschle, who is chairman of our department of community medicine, to pick up at this point.

STATEMENT OF KURT DEUSCHLE, M.D.

Dr. DEUSCHLE. Congressman Scheuer and Senator Javits, it is a great pleasure to be here and have the opportunity to present testimony. I have prepared my remarks in written form and they are available to you. I thought I would be rather informal though at this point in the presentation.

Mr. SCHEUER. Your remarks will be printed in full in the record. [See p. 192.]

Dr. DEUSCHLE. Thank you very kindly. I would like to share my time with Mrs. Ingram.

Mr. SCHEUER. Fine.

Dr. DEUSCHLE. I had not met Mrs. Ingram myself until this morning but the basis of her presence here is that we have been working in the East Harlem community for the past 8 years and at Mount Sinai and we have provided technical assistance to various community organizations. Mrs. Ingram is a member of that patient population that is served by a neighborhood health center, which Mount Sinai helped to establish. I requested that a representative mother from that neighborhood health center come down and present their views of what has been happening in the inner city of East Harlem with respect to health services and point out to you some of the problems which she faces as a mother in the neighborhood. She could also comment on some of the opportunities she has experienced since the development of an adequate primary care system available to her community.

I feel like I am bringing coals to New Castle to you, Congressman Scheuer, with respect to the data on the inner city because you spelled out so very clearly and precisely the problem which we are experiencing here and across the Nation. I want to mention that my interest in this problem comes from the fact that I have worked 24 years in underserved areas: 8 years with the Navajo Indians, 8 years in Appalachia, and now 8 years very largely concerned with East Harlem. I won't do more than just give you some characteristics of East Harlem as a community so that we can all understand the context in which Mrs. Ingram lives.

As you know, East Harlem is that part of Manhattan that is bounded on the south by 96th Street, on the north by the Harlem River, on the west by Fifth Avenue and on the east by East River. East Harlem has a population of about 154,000. Every parameter of its socioeconomic pattern indicates that it is an underserved area. The population is approximately 50 percent white, but most of the population is Hispanic in background; about 40 percent are blacks.

We have sufficient secondary and tertiary health service resources in East Harlem. The problem that we have documented is the lack of good primary care facilities. School health is just one area of health services which presents a major defect in the primary health care system.

Mr. SCHEUER. The record should indicate that Senator Javits is very interested in this.

Dr. Deuschle. We know many health problems exist in schoolchildren. Dental care needs are prevalent; malnutrition in the form of overweight children is another common problem.

These children are probably getting too much in the way of carbohydrates and starchy foods and too little protein. We have already uncovered a serious problem with visual difficulty. We conducted surveys in East Harlem with our ophthalmologist, Dr. Safir. In one such survey Puerto Rican girls between the ages of 9 and 13, were found to have a prevalence of 60 percent nearsightedness. This can certainly interfere with learning so here is a health problem that can have very serious impact in the growth and development of that youngster.

Mr. Scheuer. Do you mean you detected nearsightedness for the first time?

Dr. Deuschle. Yes; in terms of a public health problem.

Mr. Scheuer. Nearsightedness that had not been corrected by glasses?

Dr. Deuschle. In terms of looking at a group of children and undertaking a careful ophthalmological survey—yes. We are talking about having an ophthalmologist provide the case-finding, which is expensive, and we also tested out an automatic refraction machine that was invented at Mount Sinai by Dr. Safir. This machine can provide accurate visual screening so we compared the machine performance with the ophthalmologist screening. In the process of comparing the ophthalmologist's results with that of the automatic refraction device, the extent of refractive errors in that population was documented.

What we found was that the myopia was much more common in Puerto Rican children but it was common throughout that group. We also found even if you gave away the glasses, if you provided the money to purchase glasses, that the compliant rate was low. I think one of the problems that we documented was that it is not enough to diagnose the problem, it is not enough to have the resources available, but there is an extensive education job that has to be done. For example, there are parents who feel it is a sign of weakness to give their children glasses. So there are some problems here, not only socioeconomically, but culturally, that have to be addressed if we are going to have any positive impact in improving vision in schoolchildren.

Mr. Scheuer. I take it under the medicaid program this educational program simply was not done.

Dr. Deuschle. This has not been done, let's put it that way.

Mr. Scheuer. Why is there such a greater incidence of visual problems in the Puerto Rican girls?

Dr. Deuschle. This we have not yet determined. It is one of the very important areas that we need to explore; in fact, we had received a grant to do this with the Health Research Council in New York but that program collapsed so our studies were halted temporarily.

Mr. Scheuer. You don't know whether it is diet or a genetic problem?

Dr. Deuschle. We don't. We have certainly taken into consideration both of those factors. We are carrying on these studies and have conducted some other surveys in Queens. Much of this data has not yet been fully analyzed.

I think what I am really underscoring is that there are severe health problems in school children and while it may not affect survival per se it does in terms of physical well-being. There are many social and economic consequences which we get from health problems of that kind.

Of course hearing we know is a problem, too, and Mrs. Ingram may wish to speak to that. With school health the biggest problem is not in the diagnosis of the difficulties but to link the health service needs with the organized programs in health care delivery in the community. Linkage between the the problems in school health and the ongoing health service programs is a terribly important priority.

[Dr. Deuschle's prepared statement follows:]

STATEMENT OF KURT W. DEUSCHLE, M.D., THE ETHEL H. WISE PROFESSOR AND CHAIRMAN, DEPARTMENT OF COMMUNITY MEDICINE, THE MOUNT SINAI SCHOOL OF MEDICINE, CITY OF NEW YORK

My name is Kurt Deuschle and I am the Ethel H. Wise Professor and Chairman of the Department of Community Medicine at the Mount Sinai School of Medicine, City University of New York. I have spent the past twenty-four years in several medical center programs related to clinical and public health problems of populations in underserved areas: eight years with the Navajo Indians in Arizona, eight years in the Appalachian region of Kentucky, and the past eight years in New York City focusing on the east (Spanish Harlem) section of Manhattan. During these eight years the faculty in my department have worked closely with community groups and organizations in East Harlem that have health interests. From the beginning the people in the community gave highest priority to health of mothers and children. Much of our technical assistance in health has been devoted to projects, demonstrations, and studies of MCH problems.

With this background you can readily understand why I would be so enthusiastic concerning the proposed Maternal and Child Health Care Act, H.R. 14822 and H.R. 14497. In my opinion the passage in Congress of this proposed legislation would have a major impact on health status in the U.S. general population but especially so in the underserved poor rural and urban populations.

I was most privileged to have an opportunity to review and comment on an early draft of Mr. Scheuer's Maternal and Child Health Care proposal in March 1976. I was pleased to submit at that time a detailed letter with my suggestions and comments which I will not repeat at this time.

What I wish to do today is comment further on the special health problems that mothers and children experience in the inner city and consequently the unique problems and opportunities which the proposed legislation would have in remedying these difficulties.

I shall refer to the inner city community of East Harlem in which the Mount Sinai Medical Center is located. It is generally described geographically as a Manhattan area bounded on the south by 96th Street, on the west by Fifth Avenue, on the east by the East River and to the north by the Harlem River.

EAST HARLEM'S DEMOGRAPHIC AND HEALTH PROFILE

The demographic profile of East Harlem is of special interest in the context of the Maternal and Child Health Care Act. East Harlem has a population in excess of 154,000 with 43 percent of residents being 19 years of age or under—compared to 31.8 percent in New York City. East Harlem is also ethnically diverse—52.5 White and 43.7 percent Black with other remaining at 3.8. Puerto Ricans comprise the majority of the population. A great proportion of the Puerto Rican residents speak only Spanish.

East Harlem is one of the poorest urban areas in the country; the median family income in 1970 was $5895 compared to New York City figure of $9682. In a special East Harlem study conducted by my department 47 percent of households reported no take-home pay during the week preceding the interview. In half of the households where one or more persons was employed, the take-home pay was no more than $100 for the week.

The percentage of families with annual income of less than $5000 (or below poverty level) is 38.9 percent in East Harlem. 72.6 percent of families have less than $10,000 income per year. One of the reasons for low socioeconomic status is low level of education. Five percent have not attended school. Twenty percent are high school educated and only 4.8 attended college for varying time periods. Unemployment is rampant with 40 percent either employed or not considered to be employable. There is high mobility among this population.

The doctor visits per year in our East Harlem survey were 3.5—significantly less than 4.5 visits per year on national average. Considering the low health status of East Harlem, the residents should be utilizing health services more rather than less. The highest utilizers of health care services are those persons with no income except welfare. This is because they are medicaid or medicare eligible.

What all these data mean in terms of health care can be quickly summarized as follows:

The high proportion of mothers, infants and children indicates a critical need for health services in this segment of the population.

The multiethnic composition of East Harlem indicates a need to understand its social and cultural characteristics. For example, bilingual programs are needed to serve a high proportion of the exclusively Spanish-speaking members of the population.

Low income of East Harlem population indicates economic barriers, particularly for the "near-poor" who are not medicaid eligible yet have no money to pay direct fee-for-service costs.

The low level of education has serious implications both in the pattern of disease and use of the available health services.

The percentage of deaths from early infant disease is much higher than Manhattan or New York City's general population figures. While leading causes of death are similar to New York City's total population—deaths due to drug dependence, cirrhosis of the liver, homicide, hypertension and its complications, and early infant disease and diabetes are higher. Infectious and communicable diseases such as TB, syphilis, gonorrhea, hepatitis, measles, salmonellosis and strep throat are at higher rates than the City.

Especially disturbing is the fact that 14 percent of the live births in East Harlem have a low birth weight compared to 10 percent in New York City. These are the high risk infants who contribute to mortality and morbidity. Another serious problem is that one-third of the live births have inadequate prenatal care. Out of wedlock births in New York City comprises 28.9 percent of total births. This certainly requires additional efforts in the area of sex and contraceptive education.

We have devoted considerable efforts to health problems in school children. We have been impressed with high prevalence of respiratory diseases, especially asthma, in Puerto Rican children. We also surveyed vision carefully using ophthalmologists and new vision screening technology—the ophthalmetron. The Director of the vision study project, Dr. Aran Safir, found an unexpectedly high prevalence of refractive error (myopia) in Puerto Rican children, especially girls. Another problem was overweight children, which in fact is a form of malnutrition—poor nutrition. This is related to low protein intake and high carbohydrate diet. Dental problems are extremely prevalent throughout the child population. Selected surveys of East Harlem children's utilization of health resources show low rate of compliance on treatment programs with inadequate follow-up on significant health problems.

An issue that has become as significant as immunizations and the actual detection of disease in school-age children is the lack of a mechanism that successfully links the school health system with different forms of medical practice within the community. Inadequately organized health strutcures, the lack of communication between schools and providers, inadequate communication (reporting) between school health services and community health care agencies, a poor system or referral and follow-up surveillance have all been cited at one time or another as reasons children continue to be untreated.

We are currently completing a project proposal in cooperation with the City, State and Federal health agencies for capitation funding of a population of East Harlem school children to determine the feasibility of improving accessibility and continuity of high quality primary and backup health services. Based on the health statistics an effective demonstration model in school health services could contribute to an improved maternal and child health service in East Harlem with far-reaching effects.

The health resources in the East Harlem area are considered to be adequate for secondary and tertiary care. The problem is in the primary care system. Episodic and fragmented care—often provided through emergency rooms is the prevailing pattern of primary care. Problems associated with accessibility and availability of primary care have been well-documented.

There are many explanations for the inappropriate or limited use of health care resources by the East Harlem population:

1. Some resources are located in the area but are not focused on the East Harlem population.

2. In many instances the population cannot use the resources for economic reasons.

3. The community does not know how to use the available resources appropriately—this largely is a lack of education and information.

There are of course many other factors that influence health which are outside the area of health care services—in East Harlem the inadequate housing, high crime, poor nutrition, and a host of other variables contribute to the difficulties of improving health status. Nevertheless, the Maternal and Child Health Care Act with its special provisions to assure adequate MCH services in inner city populations such as East Harlem, can make an enormous impact. Provision of support such as community health outreach workers to high risk families, better transportation, baby-sitting services if mother has medical problems that would prevent her from keeping a clinic appointment, bilingual and culturally sensitive health professionals—these are but a few of the important supporting social services that would insure high quality health care.

Perhaps even more important is the emphasis which your legislative proposal provides to encourage public and private nonprofit organizations to develop organizationally sound and responsible health services. The East Harlem Tenants Council (Taino Towers) Neighborhood Health Center is a community based and community sponsored primary care facility which is operating effectively in the northern sector of East Harlem. It has the backup secondary and tertiary care support from Mount Sinai Hospital. This mini-regional subsystem of health services can be a model for implementing the maternal and child care proposal in this special population group. If we are to utilize our health resources optimally, and guarantee accessibility, and continuity of responsible health care, our primary care programs must be appropriately linked to the secondary and tertiary care centers. Incentives that may stimulate and reinforce the linkages of these resources by H.R. 14822 will be a major contribution to realizing the objectives of the MCH proposal. Special attention might be directed to enrolling school children populations into health care programs where careful evaluations of outcome of health care on health status can be precisely ascertained. Although I personally favor a capitation payment scheme for such an organized defined population, fee-for-service could also be effectively developed for this program.

I wish to thank the Committee for the opportunity to review some of the special pressures which the maternal and child care problems of the inner city population may generate. As further details of the proposal are worked out I trust that the unique features of various underserved population groups will be addressed in context of their life style and community resources.

Dr. DEUSCHLE. At this point I am going to stop simply because I feel that Mrs. Ingram can give us some insights into the problem areas that she has faced and then we can come back to some of the possible solutions.

Mr. SCHEUER. We are delighted to have you here with us, Mrs. Ingram, and it is generous of you to come and spend the time with us. We are looking forward to your insights and what we can learn from you.

STATEMENT OF PAT INGRAM

Mrs. INGRAM. I have three children, a son 5 and a daughter 11 and a daughter 12. All three of them are hard of hearing. I found it very hard to believe when I started having children that when the child reached school age they received no medical care anymore unless there are lots of hospitals that you can go to for emergency treatment, but as far as preventive there was nothing. After a child got to be school age they went to school and you no longer were eligible to go to the public health station which really only gave you shots anyway. There was nobody to examine the children's eyes.

The first time I sent my daughter to the dentist the child had nine cavities. She must have been about 9 years old the first time she ever went to a dentist and that is because I took the money and went to a dentist because there are no services that I could take her to.

Now with the East Harlem Tenants Council they do have the health facility where my daughters are seen and they have physicals. I am helped with problems that they have in adolescence. They have a lot of problems and I have somebody that I can go to now and talk to who can help me out with the problems and who can counsel my children. This is something that is needed—a lot more is needed. We cannot just have, you know, when you turn your child over to school that is it.

The eye exams they give in school are nothing really. The hearing tests that they have in school are really nothing and you need something to take your child to other than just an emergency room, a doctor that does not know your child from a hole in the wall. At the East Harlem Tenants Council I see the same doctor all the time and the same nurses all the time for my children and this is a great help but it is something that was just started and it has only been going about a year. If funds are cut, it probably will be stopped and once again my children will only see a doctor when they become sick, when I take them to the emergency room.

Don't tell me what it is for, how to explain why they have to take this and the importance of it. If I don't feel comfortable about giving it to them, I won't give it to them. If I don't feel I have confidence in the doctor, just drag into the emergency room, open up your mouth—that is it, you know. You really do need a lot more than just emergency room treatment. They really can only take care of so many children and so many mothers. You do need a lot more.

Senator JAVITS. We would like to know from you, at least I would, whether that is a federally supported program, and what it depends on. Mrs. Ingram says they may cut off the money.

Dr. DEUSCHLE. Let me give you 1 minute of background on that point. When we saw these kinds of problems in East Harlem, those of us in community medicine worked very closely with the city health department and established a Wagner child health demonstration project sponsored by city and model city funds. We tried to demonstrate that you could provide comprehensive care for the children under 5 not only when they were just there for shots but when they were sick as well. So this is a very small pilot study in which we used nurse practitioners, community health workers, good health system records and close collaboration with the neighborhood community.

One of the community organizations known as the East Harlem Tenants Council, which had a long interest in housing, turned their attention to health. They appreciated the program at the Wagner Child Health Station and proposed to take over the project and expand it to a neighborhood health center. Collaborating with this group we submitted a proposal funded by HEW and this provides the basis of a neighborhood health center which not only handles the group of medicare and medicaid but also is funded for the near poor and of course the third-party payers.

This program has been going on now for a period of at least a year since it was taken over from Mount Sinai and the city health department. I think what is important here is that it demonstrates the importance of a primary care development in a community such as East Harlem. This has made it possible for Mrs. Ingram to have a doctor and a nurse that she can count on. This primary care simply defined is simply the resource and health care delivery which has the first point of contact but in addition to that first point of contact continues health responsibility for the individual and makes sure that a range of services are available—not only those that are commonly needed but to have linkage with secondary and tertiary facilities.

Now Dr. Pomrinse and my own group have given backup services from Mount Sinai to this neighborhood health center. There are so many special problems, as I mentioned, it is not only having the primary care which all of us need but in these special circumstances having people who have, say, a bilingual capacity with professionals who can speak Spanish with their patients.

You may need babysitting service, you may need transportation, you may need education in nutrition. These services are all available there and need to be expanded. As the authors of this legislation I encourage you to provide the means and incentives to provide additional primary care services. I think we have just seen the beginning in East Harlem of community organized primary care resources.

Mr. SCHEUER. Do you feel that our bill provides a sufficiently broad range of backup services?

Dr. DEUSCHLE. It is stated categorically and I find that very encouraging. I think, however, as you get up close to each individual situation that there is a need to provide incentives that will enable, for example, medical schools and hospitals and other quality institutions to work closely with community groups. As you know from this discussion, this East Harlem Tenants Council Neighborhood Health Center is sponsored by the community—they run the show, they make the applications. We simply provide technical assistance.

Mr. SCHEUER. Can you give us a laundry list of support services that you think at a minimum should be provided?

Dr. DEUSCHLE. I think that perhaps the most important one would be the community health worker and this would be a person who is defined as a linking professional between the community citizens and residents and the health professionals. These are individuals who would be knowledgeable about the simple and common problems and can educate a mother at a point in time when she is in need of guidance in care of her child. These individuals who are culturally identified in the same way, have similar language background, would be able to be extraordinarily good health educators.

Mr. SCHEUER. I would think that a community health worker would also be a good educator for a Congressman or a Senator because sometimes, Mrs. Ingram, when we hear from professors and doctors it tends to get very theoretical and complicated and it is not always so clear to us, but when somebody like you comes down here and tells it like it is and tells us in very simple, clear language how it affects you as a human being and your family. It gives us a lot of clarity and understanding that we don't always get from the doctors and the professionals. So we thank you particularly for coming down here and testifying.

Mrs. INGRAM. I wanted to say something.

Mr. SCHEUER. Please do.

Mrs. INGRAM. You said before that medicaid provides for family planning.

Mr. SCHEUER. Yes.

Mrs. INGRAM. Well, most of the family planning centers, I don't know if you know it or not, they have been closed. There was a cutback in funds and a lot of them have been closed down. I have run from one to the other and they have closed, and as I have gone to another one that one has closed. The East Harlem Tenants Council now does have family planning but a lot of them are closed now and everybody does not qualify for medicaid. It is the person who cannot afford to go to private doctors and is not at the medicaid level that is really suffering.

Mr. SCHEUER. Caught in the middle.

Mrs. INGRAM. Yes. Before they had the East Harlem Tenants Council I would never go to the doctor for myself because I could not afford it really and my daughters didn't see a doctor because I could not afford it unless they were sick and I went to the emergency room and I paid heavily in the emergency room. So you have to address yourself more than just say, "Well, medicaid," you know, because there are other people who are in it in between and those are the ones that really suffer more so than anybody else.

Mr. SCHEUER. Also in medicaid, family planning services are not available until you have had your first child.

Mrs. INGRAM. Right.

Mr. SCHEUER. I want you to know that you are not talking to somebody who is disinterested in family planning. I was the author of the 1970 population research and family planning services bill. I am deeply committed to family planning and I think it is an additional outrage that a third of the counties in the United States have no family planning services whatsoever.

In the metropolitan area of New York there are family planning services available but they are not conveniently available as you indicate and you have to really ferret them out and hunt them down. I think we have a long way to go in providing family planning services. In the 1970 bill that I authored we provided family planning services to every woman in the United States in their childbearing years implemented over 5 years. Five years have come and gone since 1970 with some to spare and we still have 3½ million women in their childbearing years in the United States who are not covered, most of them outside of metropolitan areas.

We are counting the metropolitan area as providing family planning services notwithstanding the fact that you point out very correctly that they are few and far between and that they are inconvenient and expensive to get to and that we don't provide transportation and provide baby sitter services. Family planning services under medicare are not available to a teenage girl until she becomes a mother which can be compared to locking the stable door after the horse has bolted. I am glad you have highlighted this national need which the Congress has identified but in terms of funding and in terms of the wherewithal to make it work we still have a long way to go.

I want to thank all of you for your very interesting and very stimulating testimony.

Senator JAVITS. Before we leave, just one question.

Mrs. Ingram, if it will not trouble you because it is sensitive, could you tell us—please don't answer it if you don't wish to—your own financial condition. Are you on medicaid? Are you entitled to medicaid?

Mrs. INGRAM. I am not entitled. As far as I am concerned, I am at the poverty level but nobody else thinks so. I am not entitled to medicaid. My husband works every day.

Senator JAVITS. Thank you so much. It is very important for us to get this in focus. It might interest you to know that we have made material increases in everything you have spoken about in the new health education and welfare appropriations. It is still in controversy on another subject, abortion, and I am hopeful it will come out soon. There are major increases in everything you have mentioned—18 percent in community health centers, 26 percent in maternal and child health, and 13 percent in family planning. So we are hoping for a little improvement.

Dr. POMRINSE. I cannot resist adding, Senator and Mr. Scheuer, that I learned this morning that at the Wagner and now the East Harlem Tenants Council program that home phone numbers of the patient's doctor and nurse are made available to the patient and they are encouraged to call whenever they think they should. Now you know I don't have this in private practice.

Mr. SCHEUER. That is right.

Senator JAVITS. That is great. We congratulate those professionals.

Mr. SCHEUER. That is really tremendous.

I think I am one of the few Congressmen who has his home phone number listed in the phone book and also includes his home phone number in all of his newsletters with the direction that in the event of a personal or family emergency don't hesitate to call at any time of the day or night. It is amazing how few people take unfair advantage of that. People are very decent and very considerate and it means a great deal to them to know, just to have that knowledge, that they can get in touch with you if they need to.

I cannot thank you enough for your very stimulating and thoughtful testimony.

We will continue to hear testimony from health consumers, but I now ask two health professionals to come forward: Dr. Richard Behrman, chairman of the Department of Pediatrics, Rainbow Babies and Childrens Hospital, Cleveland, Ohio, and Dr. Raymond L. Vande Wieler, chairman of the Department of Obstetrics and Gynecology of the College of Physicians and Surgeons, Columbia University.

Senator JAVITS. I regret that I must leave the hearing at 12 o'clock to preside over a hearing of a subcommittee of the Foreign Relations Committee in Washington.

Mr. SCHEUER. Please go ahead. You can either read your remarks if you have them prepared or you can simply talk to us.

STATEMENTS OF RICHARD BEHRMAN, M.D., DIRECTOR OF PEDIATRICS, RAINBOW BABIES AND CHILDRENS HOSPITAL, AND CHAIRMAN, DEPARTMENT OF PEDIATRICS, CASE WESTERN RESERVE SCHOOL OF MEDICINE; AND RAYMOND L. VANDE WIELER, M.D., CHAIRMAN, DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, COLLEGE OF PHYSICIANS AND SURGEONS, COLUMBIA UNIVERSITY

Dr. BEHRMAN. I am Dr. Behrman and my experience is twofold. One, I am presently director of pediatrics at the Rainbow Babies and Childrens Hospital and chairman of the department of pediatrics, Case Western Reserve School of Medicine. I was formerly here in New York at Columbia College of Physicians and Surgeons. I would like to bring to you a perspective on this bill from two vantage points, Cleveland and New York.

Mr. SCHEUER. That is fine.

Dr. BEHRMAN. First I would like to indicate strong support for the major thrust of this bill. The suggestions that I hope to offer are offered from the point of view of improving the quality of the bill.

Senator JAVITS. Dr. Behrman, you were at a meeting in my office.

Dr. BEHRMAN. Yes.

Senator JAVITS. I just wanted again to express on the record my thanks and I am sure Congressman Scheuer thanks you for your cooperation.

Dr. BEHRMAN. Thank you.

Senator JAVITS. Dr. Vande Wieler, you were there, too.

Dr. VANDE WIELER. I had Dr. Charles substitute for me.

Senator JAVITS. Thank you.

Dr. BEHRMAN. I think overall the fact that this bill presents an incremental step toward a national health insurance program is a sensible way to go, particularly if it is part of a general plan for coverage of most of our population some place down the line. I think the advantages of this approach is in terms of costs and the ability to work out the mechanisms for implementation before a heavy investment is made. This is just commonsense.

Second, by focusing on fetuses and children I think one can maximize the payoff in the long run for improving health conditions in adults. I think here in particular, as was mentioned by a previous speaker, the preventive services in pediatrics and obstetrics and gynecology are ahead of other areas of medicine by nature of the applied technical advances that have been made. There are a number of preventive health techniques that can have direct ramifications in decreasing mortality and morbidity for children. In addition, pediatrics is ambulatory care based rather than hospital based. The vast majority of care given to children is ambulatory care: tertiary care or hospital care is of less importance proportionately for children than for adults.

I think also the receptiveness of the physician professionals and the non-physician professionals for health care for pregnant women and children is likely to be considerably greater and more enthusiastic than in some of the other areas of the medical care.

Finally another dimension of this bill is that it allows one to move into the regional provision of primary care services in an area of medicine where there has already been a good start. Regionalization of prenatal health programs for mothers and pregnant women and their fetuses as well as for a new born infant is already on the way throughout most of the country. There is considerable experience being accumulated in this and it would be perfectly reasonable to transfer this to providing further services for this population as they grow.

Now as to the bill itself I have several suggestions. I would like, if I could, to run through these quickly. One. I fully support the group practice idea as a component of the bill. My major reason, in addition to the reasons that have been offered in terms of cost control, is that it offers probably one of the most important ways to provide quality control. My own experience has been that general groups of professionals practicing together in the care of children are more likely to offer a better consistent quality of care. The problem of the need to call upon other subspecialists can be worked out on a technical basis in terms of special consultant arrangements without much difficulty.

Second, the definition in section 212 of a pediatric unit needs further work because in general in the country today most pediatric units care for children up through the age of 18 and more especially when dealing with children with cystic fibrosis, children who have malignancies, et cetera, pediatric care is continued well up to the end of their teens and often into their twenties. Some type of special provision that is more elaborate than the age breakoff indicated at section 212 in the legislation would make sense.

Third, section 211 which deals with dental services and excludes dental services before 4, needs rethinking. I am not an expert in this area and I think it would be worthwhile getting some input from dentists on this. At least for preventive dental services before the age of 4 it might make sense to cut down the problem that was mentioned by the last lady who testified about caries in her own children. There are ways to avoid having nine cavities at 9 years of age by employing dental services early.

Mr. SCHEUER. What is the earliest age at which a middle class family would take their child to a dentist?

Dr. BEHRMAN. I think at least in my experience in Westchester, for example, the dentists encourage middle class families to have their children come in just at the end of toddlerhood, in other words 3 or 4, for a check and at that point institute dental services which may really only consist of fluorides and——

Mr. SCHEUER. Age 3 or 4.

Dr. BEHRMAN. Yes, so that I think you might want to start before 4, but I would suggest getting some dentists involved in this judgment because I am not expert in this area.

Fourth, the drug section, section 217, I interpret as an effort to try to control the use of drugs excessively and inappropriately. However, I think it needs some further working because for a large number of problems, particularly infections, you would want to treat from 7 to 14 days with antibiotics, depending on the particular antibiotic, and this section would exclude this appropriate area for therapy. It would exclude the bulk of drugs that are really called for in treating children because in general one does not treat chronically for many childhood diseases. I think the 20 day criteria is a crude cutoff that needs to be reworked.

Fifth, concerning the comprehensive maternal and child health units, section 402, there is a comment about the main source of income from practice which I think one might want to qualify. When dealing with large academic health centers in urban areas there are practicing physicians who derive part of their income and professional educational activities. Some of these physicians might spend 50 percent of their time delivering primary care. He or she might also spend 50 percent of their time in educational activities. This section is a little too narrowly defined; it might exclude a valuable resource.

Sixth, the limitation of services in section 211(b)(4), page 27 of the copy of the bill I have, needs to further. I fully approve of the comment about requiring second opinions for tonsillectomies and adenoidectomies but I think one could elongate that list and maybe include special diagnostic procedures. One could appropriately generate a longer list than just those two procedures.

Seventh, section 202(2) (A) through (E)—the definition of pediatric units leaves much to be desired. I won't go into it in detail but I think that the criteria of 12 pediatric beds needs to be further elaborated. I think in Senator Javits' office when there was a meeting on this bill a number of suggestions were offered. There are excessive numbers of small, low quality and/or high cost pediatric units throughout New York City, and throughout Cleveland. This needs to be dealt with in a way that will promote incentives for hospitals and pediatricians not to continue to perpetuate those inpatient units, although you may, at the same time, want to have those same hospitals continue outpatient services. I think the definition here in terms of 70 percent occupancy and 12 beds is really too crude and misses an opportunity to do a better job in terms of cost containment and improving quality of care.

Section 202(3)—I am not sure of the subsection because I didn't note it down—page 22, line 2, mental illnesses are excluded. I understand the reason for this in terms of the difficulty of controlling the cost of those services. Do you intend also to exclude mental retardation because that is one of the main problems, particularly in the chronic care. Most of the chronic care facilities for children which spend a lot of their time on that population would be excluded from being reimbursed. I don't know whether this was the intention or not. I would strongly urge that it not be the intention and that at least mental retardation be included. This should help to improve the quality of care for mentally retarded children throughout the country in convalescent settings.

Mr. SCHEUER. How do you draw the line between health services for mentally retarded children and special education services for mentally retarded children? After a certain point does it not become a question of providing needed educational services to maximize the potential of the mentally retarded and giving them education that is relevant and reflective of their special needs?

Dr. BEHRMAN. I agree, and I think this is a problem. I would have to give more thought as to how one would do it and not assume the cost of the whole education.

Mr. SCHEUER. I don't think we could do that under this bill.

Dr. BEHRMAN. I agree with that.

Mr. SCHEUER. I was the coauthor years ago along with the then Congressman Hugh L. Carey of a bill which would have provided special education programs. At that time, Congressman Carey and I felt strongly that kids with special education needs comprised at least 10 percent of the population but nevertheless got the short end of the stick. At the same time I think the Senator and I would have to think carefully about imposing the cost of perhaps a decade of special education for the mentally retarded in what is essentially a health services bill and at that a bill that is designed to be essentially preventive health services. Perhaps if you could give us a little memo on this subject we would be glad to include it in the written record. We will hold the record open for some thoughts from you.

Dr. BEHRMAN. I will do that.

Mr. SCHEUER. We would appreciate it.

[The information requested was not available to the subcommittee at the time of printing.]

Dr. BEHRMAN. I would just like to focus on one more thing that relates to the whole cost problem and that is part C, section 32. One of the major problems is to provide hospitals wtih incentives to provide for those inpatient services that are required for children as well as for the pediatric outpatient services and to do it in a more management efficient way, controlling costs, especially personnel costs and ancillary costs. One of the problems, for example, is the productivity of personnel in such units.

Now as I am sure you gentlemen are aware, the present hospital accounting systems are such that they are organized by accounting principles to maximize the hospital's position in going to third parties to get reimbursement. They tend to shift costs to the income producing units, away from, for example, housekeeping. Now the end result of that is to shift excessive costs to the ambulatory outpatient area, costs that don't reflect the true costs of that operation and also to allocate costs to units within the hospital without connection to the actual services provided by the specialized units.

I would think that careful thought should be given to the possibility of structuring into this bill a requirement that institutional providers in both the inpatient and the ambulatory setting organized their accounting so as to make specific programs and patient care services cost responsibility centers so that one can look and see for each activity in the ambulatory area or in the inpatient area dealing with children really what the net balance sheet shows as to what is the real cost versus the income. This would give hospital managers incentives for optimally organizing the personnel in those units.

I would like to conclude on this point and turn the microphone over to the other guests that are here this morning. Thank you.

Mr. SCHEUER. Thank you very much.

We will now hear from Dr. Raymond L. Vande Wieler.

STATEMENT OF RAYMOND L. VANDE WIELER, M.D.

Dr. VANDE WIELER. I wrote a letter to Dr. Javits in July which would be the basis of the testimony here and again I would prefer to include that in the record.

Mr. SCHEUER. Yes, the letter will be included in the record at this point.

[The letter referred to follows:]

COLLEGE OF PHYSICIANS AND SURGEONS OF COLUMBIA UNIVERSITY,
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY,
New York, N.Y., July 23, 1976.

Senator JACOB K. JAVITS,
U.S. Senate,
Washington, D.C.

DEAR SENATOR JAVITS: As requested by your office, I am submitting hereby my reaction to the bill sponsored by you entitled, "National Health Insurance for Mothers and Children (S3592)." I will limit my remarks mainly to the obstetrical aspects of the bill. If these reflect to a major extent my concerns as Director of an Obstetrical Service of a teaching institution whose patients come predominantly from a low economic, inner city population, it is certainly not because I am ignoring other aspects of obstetrical care but rather that I want to limit my comments to areas in which I have special expertise.

You are well aware that in terms of perinatal mortality the United States trails behind most developed countries. In fact, our perinatal mortality is higher than that of some developing countries and more disturbing, our ranking has been deteriorating progressively over the last years. This is not the place to analyze in detail the reasons why a country that is otherwise the unquestioned world leader in health care, performs so poorly in terms of perinatal mortality. Some of these probably cannot be legislated away, others can be remedied by enlightened legislation such as the one proposed by you. Your bill would remove most of the financial strictures that, at the present time, prevent a significant part of our population to have access to the best perinatal care. Incidentally, the population that suffers the most from these strictures is not the true indigent group but the population living just above the poverty level and the lower middle classes. However, I would like to see incorporated in your bill some changes in health care delivery that in my opinion would help greatly toward reversing the deplorable state of perinatal care in the United States.

Health care expenses have become progressively a major burden to the American economy. A significant factor in the explosive growth of medical costs is the increasing complexity of diagnostic and therapeutic methods which, while saving or prolonging lives, do so only at enormous cost. In medicine and surgery, for instance, the development of intensive care units has literally revolutionized the prognosis of the acutely ill patient. In obstetrics, a similar revolution is at the present time in progress and in hospitals where such obstetrical intensive care units have been organized, we are rapidly moving to perinatal mortality rates in the neighborhood of 10 per 1,000. The number of obstetrical intensive care units that are needed, however, is quite small as is clear from the following example. It is generally assumed that 10% of obstetrical patients are "high risk patients"; therefore, a hospital with 1,500 deliveries will have approximately 150 high risk patients per year. In other words, the intensive care unit of such a service (and I am not only considering the very expensive resources of such units but even more, the expenses of maintaining a highly skilled staff) may go for several days without having a single patient to take care of. It is clear that here there is a possibility of a very significant waste of money which can only be prevented by having hospitals with obstetrical intensive care units serve as referral hospitals for all the other hospitals in a certain region.

You may be aware that in July of 1975, the Robert Wood Johnson Foundation awarded grants to eight medical centers in the United States to assist in the regionalization of perinatal care. The grants were awarded with the expectation that the regionalization would lead to a reduction in perinatal mortality and morbidity rates in the areas in which the institutions are located and that these networks would then serve as models for regionalization elsewhere in the United States. Equally important in the decision of the Foundation was the consideration that by sharing facilities and professional skills throughout the area, a significant reduction in the expenses of maternal and infant care could be achieved. The Obstetrical Service at Columbia-Presbyterian Medical Center is one of these demonstration projects and our perinatal network covers the major part of western Manhattan. Incentives towards such regionalization should, in my considered opinion, be a major feature of your bill. I am convinced that regionalization of perinatal care would go a long way toward improving perinatal mortality at no increase or perhaps even at a decrease in cost. Regionalization would however require major readjustments in reimbursement policies. For instance, reimbursement from third parties at the present time is to individual hospitals and there is no good mechanism for reimbursement of one hospital by another hospital for shared facilities. If one hospital would be responsible for the high risk patients of a whole region, this reimbursement rate should be proportionately adjusted.

A second important principle I would like to be built into the bill is that of outreach programs. Experience with low economic patients (where, because of medicaid, financial restrictions are not significant) has shown that even where financial constrictions do not exist, they do not necesarily have access to, or search out, the best medical care. In New York City, for instance, there are several districts where, in 1973, perinatal mortality was 42 per 1000, whereas in the rest of the City perinatal mortality was 22 per 1000, a figure which is close to the overall perinatal motality in the United States. Yet, the people in these districts live within blocks or at best miles, from hospitals where they can have the best perinatal care. At Columbia-Presbyterian Medical Center, for instance, which is within blocks of several of the above mentioned high risk districts, the perinatal mortality on our ward service (drawing patients from the lowest economic groups) is 14 per 1000. It is clear that a significant reason for the high perinatal mortality in New York City is that patients stay outside existing medical channels even if there are no financial barriers. An aggressive outreach program should be able to remedy this problem but funds for such outreach programs at the present time are virtually nonexistent.

A third feature I would like to see incorporated in the bill is that of preventive medicne. Although all official medicine and the government agree on the importance of preventive medicine, reimbursement agencies pay little lip service to this important health problem. Patient education is perhaps the most important measure we can develop to improve perinatal care, but patient education is not a reimbursable item. By incorporating funds for preventive measures (including patient education) in your bill, you would set an example that in my opinion would be a milestone in medical legislation.

I have some additional comments on specific stipulations in the bill. In referring to these specific items, I am using the pagination and divisions of the digest of the bill which accompanied your letter.

Page 3: III, B, 1.

In the section on reimbursement of professional services for pediatrics, there were several restrictions to reimbursement (requirement for board eligible certified surgeons, second options, etc.). There are no restrictions for the reimbursement for maternity benefits. Abuses in the maternity area are probably more likely and certainly potentially more dangerous than in the pediatric area. Until a few years ago, most procedures in obstetrics were within the skills of the average obstetrician and gynecologist and could be carried out in the average hospital setting. This is not true anymore. The degree to which it has changed is evidenced by the fact that recently a subspecialty board in perinatology has been established. Certain professional services should not be reimbursed unless carried out by properly qualified physicians working in properly equipped facilities.

Page 3: III, B, 2.

Restrictions similar to those for reimbursement of professional services should also apply to reimbursement for institutional services. This specifically applies to intensive care units in obstetrics, and these should be common for the whole region.

Page 3: III, B, 3.

To reimburse for alli laboratory diagnostic services required during pregnancy could lead to very serious abuses. Recently, there has been an enormous proliferation of new expensive diagnostic services during pregnancy. Most of these are only required in a small fraction of pregnant women although it could be argued that if unlimited monies are available they are useful in most, if not all, women. Examples of such diagnostic services are various hormone assays, serial ultrasonographic examinations, etc. One way of preventing abuses would be to limit reimbursement for certain diagnostic services to settings approved for high risk obstetrical care. Once more in this respect, I would like to emphasize the importance of centralizing facilities throughout an area.

As far as drugs are concerned, it has been the experience in all countries where capitation medicine is the rule that the number of drugs prescribed goes up rapidly after capitation has been introduced. A small copayment from all patients other than the indigent would probably reduce this possibility.

Page 4: III, D.

The built-in incentives for the organization of comprehensive material and child health group practices are an excellent feature in the bill. Such group practices should integrate paraprofessionals as well as professionals and groups should have established patterns of referral to the major perinatal centers.

Page 5: VI, A.

Although Section A dealing with institutional reimbursement does not include a restriction based upon costs in preceding years (such as is done in Section B), at present, negotiations about reimbursements between medical institutions and "third parties" include such restrictions. Such restrictions, although reasonable in other circumstances, would not be so in maternity care. The major breakthrough in the diagnosis and the treatment of the high risk patient in obstetrics has come much later than similar breakthroughs in specialties such as surgery and medicine. In fact, the most important developments have come since 1974 and many hospitals because of limitation in reimbursement have been unable to incorporate these advances in their obstetrical services.

Page 5: VI, B.

The fee schedule that is referred to in this section must be better defined. As mentioned before, in the last few years, a new kind of obstetrician has evolved who has had significant additional training in high risk obstetrics. He should not be compensated according to schedule paid to obstetricians of the pre-perinatology period.

Page 6: VIII, A.

To make hospitals qualify for benefits based only on the criterion of the number of deliveries is a dangerous process. Number of deliveries is an important criterion but there are may other criteria that should determine eligibility for maternity benefits. Criteria such as integration between individual hospitals into a network, with shared facilities, availability in the specific hospital of sophisticated physical facilities and professional skills should be additional criteria. It probably would be necessary to designate certain hospitals as eligible for high risk obstetrics. No hospital should be qualified as eligible for high risk reimbursement unless at the same time it has a similarly sophisticated intensive neonatology unit.

In concluding, I would like to raise the question of "deductibles" in national health insurance plans. It is my opinion that where medical care is delivered, the patient should contribute directly a portion to the cost of the service. The "deductible" approach seems to me the preferred approach since this could be adjusted to the income of the individual and would not penalize the poor.

I want to congratulate you once more for your foresight in sponsoring this bill which should make it possible to extend to all mothers and children the benefits of a type of medical care that is available now only to a small fraction of the population.

Sincerely,

RAYMOND L. VANDE WIELER, M.D.,
Chairman.

Dr. VANDE WIELER. I am not going to repeat much of what Dr. Behrman said. I agree that many of his points are very important. I would like to limit my comments mainly to certain aspects which obviously I am more familiar with. Three aspects in the bill I think I would like to have reinforced. First, a more general comment that Dr. Behrman said, but I wanted to inject two figures into the record. One is that recent calculation by the staff of the national foundation showed that at the present time it costs the March of Dimes $30,000 to maintain a handicapped child.

So in terms of the urgency of this bill, let's say, or the reason to start with maternal care aspects of health care in terms of the national health insurance I think the case for maternal infant care is financially a very good one. Also, in terms of quality of care—again it is more known by most but not often realized—that in terms of mortality the United States, otherwise a leader in health care, is far behind most developed countries, in fact somewhat behind in prenatal care. We are 18th in terms of prenatal care. As I mentioned, most developed, and some developing countries, are ahead of us. So I think this is worthwhile in terms of a bill to keep this in mind.

The three aspects I think I would like to have strengthened and comment on are these. One is the matter of regionalization of obstetrical care. Obviously it is well known that the costs have been exploding recently in health care. One of the significant reasons is the cost of expensive services such as intensive care units where, obviously I would say, the cost in turn can often be questioned merely in terms of units. I think in terms of intensive care units, obstetrics and pediatrics are more difficult to question in terms of the figure I gave before of $30,000 per child that will be saved.

Now in terms of obstetrical and intensive care the bill, for example, wanted to restrict reimbursement in certain aspects. I would suggest that there should be other restrictions put in there.

I will give just one figure. Generally speaking most of us will accept that 10 percent of the women who are pregnant are high risk. The percent will differ obviously depending on the population you are dealing with. Even if you accept the 10 percent, which is probably high, the hospital that delivers 1,500 patients a year will have, per year, 150 high-risk patients. In other words, the hospital will go for 6 days, perhaps maybe a week, without a single high-risk patient.

In other words, the expensive facilities, the highly skilled personnel that is necessary for such care will not be utilized. I think attention perhaps should be given in this bill to why the regionalization such as areas that, as an example, comprise 12,000 patients—12,000 obviously is a figure that is a very realistic figure. It depends on the population that you deal with.

I would very much consider this possibility and not let, say, each hospital that has sufficient facilities be underutilized.

Mr. SCHEUER. Excuse me. I don't understand your arithmetic. If you have 1,500 births a year, then you would have 3 a day?

Dr. VANDE WIELER. No, you will have 150 high risk.

Mr. SCHEUER. You will have 150 high risk?

Dr. VANDE WIELER. Who need special care.

Mr. SCHEUER. So you have three a week.

Dr. VANDE WIELER. Yes, but this may mean 0 to 10.

Mr. SCHEUER. Yes, I see. In other words, you can detect those high-risk patie[illegible] long time in advance of the actual birth?

Dr. V[illegible] WIELER. No. You can detect approximately 60 percent. The other ones become high risk during the actual delivery.

Senator JAVITS. You would have a regionalized intensive care unit to look after those high-risk cases?

Dr. VANDE WIELER. Exactly. Now, obviously, depending on the geography, you would have to have more or fewer. For example, in New York City I would say where, there is communication, you would have in an area upstate New York.

Senator JAVITS. Mr. Chairman, I happen to have Dr. Vande Wieler's letter. Can we submit that now?

Mr. SCHEUER. Yes, indeed. We mentioned that would be printed in its entirety.

Dr. VANDE WIELER. In terms of your staff it might be useful perhaps to mention Dr. Behrman mentioned already to look at an experiment that is going on in the country about regionalization in support of the Howard Johnson Foundation. There are seven centers in the country that have such networks. I think it might be well to look at this. It started actually in October 1975, so therefore it is quite recent.

The second point I would like to make is I would like to emphasize or have the bill make possible for most of the networks as well as for individuals to have outreach programs as an example. I think that in the networks there should be efforts to channel patients into the networks.

Let me give you some examples. Columbia University has a major teaching affiliate at 168th and Broadway. At the present time we have a mortality of 12,000 in our low economic group. I don't have the figures beyond 1974 because they are not available. In Harlem some city blocks will run 30,000 and 60,000. In 2 miles you may have a difference in mortality of fivefold and certainly of fourfold, and the reason is not because this patient cannot come to the center, it is because they don't.

The experience of the medicaid mills is a very clearcut one. The patient goes to the medicaid mill because he feels more comfortable there and also because it is close. I think this can only be remedied by having the programs of the major networks of the major centers.

Senator JAVITS. That is provided for by the bill.

Dr. VANDE WIELER. Well, it was not explicitly stated but, if so, I think it would be a very important grant.

Mr. SCHEUER. Yes, we specified for particular groups where it is indicated support services like education, like transportation, like babysitting would be provided.

Senator JAVITS. Outreach is section 233(a)(3). You might look at that, Dr. Vande Wieler, and see if it is satisfactory.

Dr. VANDE WIELER. No. The third feature I wanted to bring up is one that had been mentioned before and to some degree this is provided for in the bill, but I think it is necessary, as far as I am concerned, to emphasize it is that of patient education. I think it is essential. I will develop one example.

If we could stop pregnant women from smoking, we probably would do better for mortality than by any of the intensive care units that we certainly have at the present time. This is obvious, it is an essential one.

Nutrition is obviously one that has been brought up over and over again, and I would like to emphasize this one as well as the general problem of patient education. I would to some degree supply centers and all groups; I would oblige them to give evidence of such indication which I think is very, very important.

Mr. SCHEUER. You are coming to the nub of the whole problem. The key to health is not scanners or tertiary hospital beds, it is how we organize our own lives in reference to smoking, in reference to alcohol, in reference to drugs, in reference to diet, in reference to nutrition, in reference to exercise, in reference to a proclivity among some of us to involve ourselves in violent situations. If we could get a handle on human behavior, I guess we could solve 80 percent of the problems of sickness. I think that is the great challenge you have ahead of you. I think you put your finger on it.

Dr. Vande Wieler. It is one of the major keys, but I think it is as important, for instance, as high risk and intensive care units. I don't want to go beyond this with the exception of maybe making two remarks. One, I think as an example in section 6(a). I would like again to attract your attention to a development that may not be so—unfair reimbursements.

The major advances in high risk care in obstetrics have come later than those in medicine and surgery and to some degree in pediatrics and therefore it is to put reimbursement of hospital or service in hospital may be unfair because the major expenses, the intensive care units have not developed in the last 2 years and in many cases development therefore of previous experience may not be a good example for future reimbursement.

A final comment which is more philosophical than anything else. I still think there should be some kind of a deductible in any reimbursement. What kind of a deductible I would not like to say.

Mr. Scheuer. That is the nub of the matter. We are all together on the principle that there should be some discouragement of frivolous overstress of the system but where we have a real problem is getting from the general to the specific. As President Grover Cleveland said a century ago, we are faced with a condition, not a theory. What is the deductible? What level of added burden do you provide that will give us some kind of a disincentive to frivolous use but not stop the mother with the kid who really needs some kind of health services from coming into the clinic?

Dr. Vande Wieler. If nothing is known, the amateurs could talk. I am an amateur in this area. I think the deductible should be attached to income and probably be zero. Let's say whatever income you want to decide is the poverty level and then go up from there.

Mr. Scheuer. We don't have a deductible for the poverty population, they are excluded from the deductible.

Dr. Vande Wieler. If I may advise you as an amateur in this respect, I would put it to income.

Senator Javits. Doctor, we have a problem but I think you have to leave it to us and we will get the advice of the experts. The problem is, does it cost more to ascertain the income level than it does to recover the deductible? It was testified to a moment ago by Dr. Pomrinse that it does if it is 10 percent. However, I think we will have to think through an automatic method by which those of low income level may immediately prove their right.

For example, if they are AFDC mothers or if they are drawing food stamps or whatever, if we can make it automaticity we might avoid that pitfall. I would like to tell you that, and I say this to the people of my city and state at one and the same time. If we do that, I hope people will realize you can never get the last rascal with the last $2. Someone will slip through the net.

Even department stores and chain stores accept a certain percentage of leakage—that is, stealing—simply because it costs much more to the consumer to have more than a given number of police or guards. People don't understand that, they get very outraged when somebody gets away with something. We have to use our judgment and we have to stick our necks out on that issue. The fact is that there will be a certain amount of fraud but that it is still in the public interest if that can be minimized to say what it would cost to prevent it in order to serve the larger good. Now if our people can understand that, we will have a very much greater opportunity in this bill than otherwise is available to us.

Dr. BEHRMAN. May I make just a comment on that. In deciding whether it costs more, I think it is important to get information, to realize the source of the information. For example, Dr. Pomrinse was talking about estimate of cost of doing that for a large hospital. Now that estimate of cost relates to the way in which they allocate costs within a large hospital.

The cost might be very different within a small group pracrice setting. There must be ways of getting at that. I mean there are experts in this area but I would not assume that a $3 cost is like $1 of a hospital, is really what it costs in a setting like the ones you are proposing to formulate, I think that is important.

Senator JAVITS. Sure. Thank you very much.

Mr. SCHEUER. Does that complete the testimony of the two doctors? Thank you very, very much for your testimony; it is very helpful indeed.

Now before we hear the panel of health consumers we are going to ask Dr. Leah Ziskin to come and talk to us. Dr. Ziskin is the director of parental and child health of the New Jersey Department of Health and she is representing Dr. Joanne E. Finley, the New Jersey State commissioner of health.

If you would care to describe your thought informally, after that Senator Javits and I will undoubtedly have some questions for you. Since Senator Javits has to leave rather soon, perhaps you could be brief and then give the Senator a chance to ask you some questions.

STATEMENT OF LEAH ZISKIN, M.D., DIRECTOR OF PARENTAL AND CHILD HEALTH, NEW JERSEY DEPARTMENT OF HEALTH

Dr. ZISKIN. Thank you.

My view is that of a State health administrator. I have under my purview family planning programs, maternal and child health, other title V funded programs and I am acquainted with the medicaid program in New Jersey. It is very fortunate that the administrator of the NJEPSDT program has come today.

I think that medicare and medicaid have served as initiating processes into national health insurance in the United States. If the new bills that you and Senator Javits propose are to be the forerunners of a more universal national health insurance for our country, I believe at this time we should be given more specifics as to the form, and provisions and the cost of this universal system.

Without this information it is easier for me to analyze the bill as it is presented and to estimate its impact upon what now exists than to view it as an increment to our universal health care plan. In this light, I am not wholeheartedly in favor of adding a totally independent program for maternal and child care to our existing systems. I think this would add confusion and additional duplication of effort to some of our existing maternal and child health care programs.

We would recommend that the new program be established to incorporate the best features of the existing systems.

I am a little confused as to the population you want to address. Medicaid would be left in place and this bill would serve the medically indigent and the private sector. It might be worthwhile to clarify that point.

Senator Javits. Doctor, as I understand it, you are confused. This is a program for mothers and children, all mothers and children. It is going to be supported both by taxpayers contributions through social security and general revenue funds for those who are not in a position, who are not paying social security, et cetera. Therefore, the whole of medicaid insofar as it applies to mothers and children as I understand it will be subsumed under this program and therefore that will represent a universe of its own which will be a threshold to a possibly broader universe though not necessarily. Congressman Scheuer is the author and he will correct me.

Mr. Scheuer. That is absolutely right. The only narrow spectrum of the mothers and children population that this bill does not cover would be mothers and children who exercise their choice to go to Harley Street doctors; in other words, the upper middle class or wealthy who go to the private doctors and who choose not to participate in any public program. I suppose there would always be some percentage of upper class and well to do who would choose not to participate in a national program just as there are elderly people who can afford their own health care and do not participate or take advantage of the medicare program. As far as we are concerned we cover the entire spectrum of mothers and children, and the Senator is 100-percent correct.

Senator Javits. Would you excuse me.

Dr. Ziskin. Certainly, and I appreciate that clarification.

The preventive health aspects of maternal and child care I feel is the one most positive feature of the proposed legislation. However, I do have some serious questions particularly on the nature and composition of the Board that the legislation proposes. I find no requirements regarding qualifications of board members nor are there clear lines of administrative authority of this Board in the bill. I am not quite sure how the Board relates to the Secretary of HEW or any of his designees. Can you clarify the composition of the Board?

Mr. Scheuer. Well, of course they are not all providers. We do have consumers on the board.

Dr. Ziskin. Right.

Mr. Scheuer. Are you talking about the Advisory Board?

Dr. Ziskin. No; the Board itself.

Mr. Scheuer. The Board of three or the Advisory Council?

Dr. Ziskin. There should be someone with medical qualifications on the Board of three and that I see as an omission in the bill.

The recommendation that the Advisory Council may appoint consultants I think would lead to a building of a whole new—let me use the term which I know is out of favor now, bureaucracy, and I would like to see this structured more within HEW than the idea that I am getting by reading about a board and a council as described.

Mr. Scheuer. Is it your view that HEW is not a bureaucracy?

Dr. ZISKIN. No; I think it is a bureaucracy but I can't see setting up a separate one outside of it and this is what I perceive in reading the bill. We would like to see it more inclusive in HEW.

Mr. SCHEUER. And you feel there should not be a provision for consultant or consultants or nonfull time experts to come in on it on an ad hoc basis?

Dr. ZISKIN. No: that is not what I meant. When I read this I thought the administrative structure proposed was exclusive to HEW and the recommendations made by the Advisory Council were to the Secretary for appointment of consultants exclusive of HEW. I felt that the consultants should either be employed full time or act as part-time consultants but that they might be more involved within the structure of HEW than acting outside of the system.

Mr. SCHEUER. Suppose we decided we wanted you as a consultant or suppose the Council decided they wanted you to consult or Dr. Pomrinse or somebody that was not in the employ of HEW. Would you say the Council should not have that option?

Dr. ZISKIN. No; the Council should have that option.

Mr. SCHEUER. Then I don't understand what your problem is.

Dr. ZISKIN. The problem is with the Council and the Board itself. Are those within the structure of HEW or are these outside of the structure of HEW? Maybe there is where my confusion is. It sounds like you are setting up a totally new administrative body.

Mr. SCHEUER. I really don't understand what your problem is. The Board would be under HEW obviously, it is appointed by the Secretary. The Council would be advising the Board. So in effect if you wanted to do an organizational chart, the Council comes under the Board and the Board is within HEW so, in effect the whole thing is under the HEW umbrella.

Dr. ZISKIN. That clarifies. I do not feel the wording in the law was that clear.

Mr. SCHEUER. Page 7, section 111. "There is hereby established in the Department"—that means the Department of Health, Education, and Welfare—"a Maternal and Child Health Board."

Then on page 12, section 121:

> There is hereby established a National Maternal and Child Health Council, which shall consist of the Chairman of the Board, who shall serve as Chairman of the Council.

So again that is under the Board. The Chairman of the Board serves as Chairman of the Council and there will be 10 members not otherwise in the employ of the United States. That means they won't be employees of HEW. There will be outside people appointed by the Secretary of HEW on recommendation of the Board; not less than six of them shall be consumers and four shall be providers. So the whole thing comes under the HEW umbrella.

Dr. ZISKIN. Let me go back to page 7. You have there, "There is hereby established in the Department"—and I guess you mean the Department of HEW—"a Maternal and Child Health Board to be composed of three members to be appointed by the President."

Mr. SCHEUER. That is correct.

Dr. Ziskin. Now it just seems unusual, but perhaps it is not, and it might be my ignorance, to have a board directly appointed by the President.

Mr. Scheuer. Not at all. Mr. Cutler tells me that the Board of the National Library of Medicine is appointed by the President of the United States.

When I was a freshman Congressman in early 1975 and we started considering the Elementary and Secondary Education Act, I suggested that we set up an advisory council that would advise the Secretary of HEW on any breach of the church-State problem in the rendering of education services to children in private schools and the degree also to which children in the private schools were not getting the facilities and services which we intended them to get. It was a rather delicate constitutional question and I, as a freshman, moved that we set up an advisory council that would provide continuing counseling to the Secretary and of course which would be appointed by the Secretary.

As a courtesy, we sent that down to the White House and within an hour we got a telephone call that the administration would support that but they wanted those appointments made by the President and not by the Secretary of HEW. Such are the realities of life. The President thought that they would be prestigious appointments and he wanted to make them personally, and I suppose that that thinking would still remain today the basic political condition of mankind being what it is.

We do have at least one more panel that we want to reach before we break for lunch, so if you could give us your final thinking as briefly as possible, we would be very glad.

Dr. Ziskin. All right. I would like to state also that, as the proposed legislation is written, the role and function of the State government is largely excluded. I think that there is a role for the State governments to play in the evaluation and standard writing of these programs as well, as was mentioned before—some work on cost containment.

Thank you.

Mr. Scheuer. Thank you very, very much.

We would now like to come forward, please, Ms. Diony Young, representing the International Childbirth Education Association, Inc., and Ms. Barbara Seaman, representing the Women's Health Lobby.

This panel will discuss with us the role of the consumer in the delivery of maternal and child care benefits. If either of you have a prepared statement, it will be printed at this point in the record in its entirety.

Do either of you have a statement?

STATEMENTS OF DIONY YOUNG, INTERNATIONAL CHILDBIRTH EDUCATION ASSOCIATION, INC.; AND BARBARA SEAMAN, NATIONAL WOMEN'S HEALTH NETWORK

Ms. Young. Yes, I have a prepared statement with some attachments which I will leave with you. I am Diony Young.

Mr. Scheuer. Then would you just like to chat with us informally? Your statement will be put in the record at this point. You can either read it or you can just chat informally and then we will ask you some questions.

Ms. YOUNG. I should like to read my statement.

Mr. SCHEUER. All right.

Ms. YOUNG. I am speaking on behalf of the International Childbirth Education Association, an organization of parents and professionals, whose purpose is to further the goal of family-centered maternity care, whereby expectant parents will have the freedom of choice in childbearing based on knowledge of alternatives through childbirth education. In speaking to title II, section 202(B) of this act, we are not advocating any one location or method for childbirth but simply the freedom for families to choose. Let me read that particular section to you.

Mr. SCHEUER. Would you repeat that? You are not advocating——

Ms. YOUNG. Any one location or method for childbirth but simply the freedom for families to choose.

That section reads:

> Only hospitals with 1,500 deliveries in an urban area and 500 deliveries in a rural area will be approved as institutions for the maternity benefits of this program.

Within or adjacent to the hospital setting are the following safe alternatives:

(1) Family-oriented options within the conventional hospital unit that allow parents to design their own childbirth experience with support from the obstetrical team;

(2) Family birthing rooms where a health mother can labor and give birth under any conditions she and her partner wish in a bedroomlike setting with early discharge as appropriate;

(3) Increased employment of nurse midwives for normal childbirth;

(4) Maternity apartment with a professional obstetrical team for the expectant family and their companions of choice where birth and postpartum can be shared in a live-in arrangement.

Mr. SCHEUER. What do you mean by "their companions of choice"?

Ms. YOUNG. Family members, friends, perhaps younger siblings.

Out-of-hospital safe alternatives include: (1) Birth centers or maternity homes under the supervision of professionally trained midwives with physician backup; (2) professionally attended and carefully screened home births.

American families have the right to safe, comprehensive maternity care that is assessible and available when and where they need it; that is responsive to their special needs; that they can afford and that is accountable to them, the consumers. But they don't have it; neither do they have a level of health care that is as high as that in many other industrialized nations that you have mentioned.

To understand better the possible effects of implementing a maternity care program such as that proposed under section 202(B), it is necessary to examine the obstetrical scene today from the point of view of the healthy informed consumer and her family.

Most people would assume that in the interests of health and safety, central to any consideration of birth, babies should be born in hospitals. But hospitals are for the sick, and the healthy mother and baby are not sick. For them the hospital environment can even pose special hazards. Dr. Roberto Caldeyro-Barcia, president-elect of the International Federation of Gynecologists and Obstetricians, stated recently, and I quote:

> In the last 40 years, more artificial practices have been introduced which have changed labor and birth from a physiological event to a very complicated medical procedure, in which all kinds of drugs and maneuvers are done, sometimes unnecessarily. Many of them are potentially damaging for the baby and even for the mother.[1]

If this is so, where are the carefully controlled scientific studies that determine the advantages and hazards of these procedures in the management of normal labor and birth? The truth is, there are no such studies, but there is extensive documentation [1] [2] on the detrimental effects of such intervention. Several of these commonly used practices may cause neurological damage to the babies of full-term healthy mothers, which was noted recently in the Journal of Legal Medicine, and I quote:

> These practices thus may pose increasing legal hazards to physicians who use them, as the general public becomes more aware of the dangers involved and of the existence of safer alternatives.[3]

Mr. SCHEUER. What kinds of practices are they referring to?

Ms. YOUNG. They are referring to practices like induction.

Mr. SCHEUER. Like what?

Ms. YOUNG. Induction of premature delivery, fetal monitoring, perineal shaving practices, the use of anesthesia and analgesia, other drugs, other obstetrical procedures that really are not necessary to use for the healthy mother.

The establishment of bonding between parent and infant, so essential for future parent-child relationships and child development, is inhibited by the separation of family members that occurs in most obstetrical units.[4] Although some hospitals are implementing long overdue, family-centered programs of care, the maternity consumer is frequently stripped of her dignity and self-respect in an impersonal environment where the convenience of staff and the imperatives of technology take precedence over her and her baby. And for this she must pay a very costly bill.

Yet present hospital management of the healthy childbearing woman is still accepted uncritically by the overwhelming majority of physicians. No longer so by growing numbers of informed parents who find the situation so threatening that they are refusing to enter hospitals to have their babies. And may I emphasize one significant fact—there is no scientific proof that hospitals are the safest place for most mothers to give birth.[5]

I should like to tell you that in 1970 a national survey by the American College of Obstetricians and Gynecologists revealed that in general, and particularly in hospitals with 500 or more annual births, the larger obstetrical services tend to have a greater incidence of mortality and that the stronger the affiliation between the obstetrical service and the medical school the greater the rate of infant and maternal deaths.

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[1] Caldeyro-Barcia, R.: "Some Consequences of Obstetrical Interference," Birth and the Family Journal 2:34, 1975.

[2] Haire, D.: "The Cultural Warping of Childbirth," Hillside, N.J., 1972, International Childbirth Education Association.

[3] Stimeling, G.: "Will Common Delivery Techniques Soon Become Malpractice?" Journal of Legal Medicine, May, p. 20, 1975.

[4] Klaus, M. H., and Kennell, J. H.: "Parent to Infant Attachment," In Vaughan, V. C., and Brazelton, T. B., editors: "The Family—Can It Be Saved?" Chicago, 1976, Year Book Medical Publishers, Inc.

[5] Stewart, D., and Stewart, L., editors: "Safe Alternatives in Childbirth," Chapel Hill, N.C., 1976, National Association of Parents & Professionals for Safe Alternatives in Childbirth.

Mr. Scheuer. I am not sure that that logically hangs together. It may be that the larger obstetrical units that are associated with the medical school tend to get the more risky cases.

Ms. Young. I was just going to continue.

Mr. Scheuer. You heard somebody talk about regionalization.

Ms. Young. Yes.

Mr. Scheuer. This is a product of regionalization.

Ms. Young. I was going to say that some of these deaths do undoubtedly result from the fact that there is a great incidence of high risk mothers in the larger teaching hospitals but it is also possible that the great tendency to intervene in the normal pregnancy and the normal progress of labor and birth in these institutions in order to provide teaching opportunities contributes to the statistics and may also result in a disproportionately high incidence of neurologically damaged children.

Mr. Scheuer. Do you have any studies that indicate that?

Ms. Young. Yes. I have references at the end of my presentation.

Mr. Scheuer. I think the references will be included. You will give us references.

Ms. Young. In their entirety the complete studies?

Mr. Scheuer. If you would give us the citations and quote a paragraph or two. We ought to know what their sources are.

Ms. Young. Yes.

Who are these families who are rejecting the pathologically oriented system? Studies [1] [2] show that——

Mr. Scheuer. Excuse me. In other words it is quite possible that this phenomenon is a result of the healthy pregnant women doing exactly what you say they ought to do if they want to, which is to have their deliveries at home. You then would have an increasing percentage of deliveries that take place in the hospital those of the high risk population.

In other words, if the phenomenon that you are talking about were to take place on an increasing scale, and you describe this as a healthy phenomenon, you would have a smaller and smaller percentage of healthy mothers going to hospitals at all, it seems to me, for their deliveries and it seems to me that it would be quite logical that the phenomenon that you discussed is consistent with exactly that trend taking place; namely, more healthy births at home, births taking place at hospitals, and particularly secondary and tertiary hospitals associated with the medical school, being the place where a mother would be referred by a doctor if it were evident that she were a high risk mother.

Ms. Young. Yes. There is nothing in between and that is the point which I am addressing. There is not anything between for the healthy but I am suggesting that we look at this with the idea of providing alternatives. I think it is important to understand the sort of people who are rejecting this pathologically oriented system.

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[1] Hazell, L. D.: "Birth Goes Home: An Ethnographic and Attitudinal Study of 300 Couples Electing Home Birth in the San Francisco Bay Area, Seattle, Wash., 1974, Catalyst Publishing Co.

[2] Mehl, L. E.: Statistical Outcomes of Homebirths in the U.S.: Current Status." In Stewart, D. and Stewart, L., editors: "Safe Alternatives in Childbirth, Chapel Hill, N.C., 1976, National Association of Parents & Professionals for Safe Alternatives in Childbirth.

There were studies to show that the parents are well educated and financially stable individuals who are not members of an ethnic minority who have made an informed decision believing that the individual, not the professional or hospital, is responsible for her own health. They distrust the conventional health care delivery system and are willing to assume the responsibility for the birth outcome. They believe that the choice of place, companions and method of birth rests with them and, indeed, they are the ones who have ultimate control over their choice of a birthplace.

Until now most health providers have ignored and criticized these families and by so doing have failed in their ethical responsibility to serve all maternity consumers. But this trend toward out of hospital births is her to stay. Let us look at the following facts.

Fact 1. In the last 3 years more than a dozen nationwide home birth organizations have been founded and are expanding rapidly. A Boston group, established 1 year ago, started with a newsletter circulation of 150; it is now over 900. It has developed, like the other groups, its own educational program for home births, training birth attendants, working with six doctors in the area, keeping careful statistics and expanding its program into southern and western Massachusetts, Rhode Island, the North Shore and Connecticut.

The recently established Maternity Center Associates, Incorporated, comprising certified nurse midwives and physicians, handled 71 carefully screened home births in its first 7 months in the Washington, D.C. area. It charges $450 which covers all prenatal care, labor and home birth and four portpartum visits up to 1 year.[1] This is one-fourth the cost of a hospital birth in the same area.

Mr. SCHEUER. For a well mother, for a healthy mother?

Ms. YOUNG. Yes.

Fact 2. The American College of Home Obstetrics has been founded to gather together physicians who wish to cooperate with families who choose home births.

Fact 3. The first national conference sponsored by the National Association of Parents and Professionals For Safe Alternatives in Childbirth was held in May this year and was attended by 520 health professionals and parents from 28 States, Canada and Australia. The proceedings[1] were published in June and should be studied very carefully by everyone involved in maternal and child health. The demand is so heavy for this book (over 20 percent going to physicians and another large percentage to State and county health departments) that it will have to be reprinted before December. Their next conference, its success assured, is in March entitled "21st Century Obstetrics Now!"

Mr. SCHEUER. Where will that conference be, if I might ask?

Ms. YOUNG. That conference is going to be in Chicago in March.

Fact 4. Recent studies in the United States are beginning to confirm the perinatal safety records of thousands of out of hospital births conducted by the Frontier Nursing Service of Kentucky, the Chicago Maternity Center and maternity services in the Netherlands and Great

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[1] Stewart, D. and Stewart L., editors: Safe Alternatives in Childbirth. Chapel Hill, N.C. 1976, National Association of Parents & Professionals for Safe Alternatives in Childbirth.

Britain. If I may refer to one of those studies, a very recent one in California of 1,146 home deliveries conducted in the San Francisco Bay area, it was found that the incidence of cerebral palsy in these home deliveries was one-tenth the national average while the incidence of mental retardation was one-fifteenth.

Mr. Scheuer. Again we are getting back to this possible logical fallacy. It is the old post ergo progo. I am very much interested in what you say and it is very stimulating. I think that underlying this bill is a philosophy that we want to get away from the sickness oriented end of the health spectrum.

Ms. Young. Yes.

Mr. Scheuer. I think we have developed a custom and sort of a tribal practice in this country that represents a philosophy that births and deaths, for some reason that I don't quite understand, should take place in the tertiary hospital.

Ms. Young. Yes.

Mr. Scheuer. So I respect what you are thinking about but I would not like the record to have an underlying logical fallacy here. Again I take it your San Francisco group is mostly upper income educated women whose doctors would be able to spot any element of high risk and therefore they would be channeled to a tertiary hospital.

Ms. Young. Yes.

Mr. Scheuer. So you are getting more and more a selection of women who have been well-counseled and who are healthy and who have been well screened and don't have any complications and have their births at home. However you can't say that because they have had their births at home their kids are healthy and have one-tenth of the rate of cerebral palsy, et cetera, et cetera. It seems to me that there is at least a possibility that it is because they have been prescreened and it is evident that they are not a high risk patient. I think underlying your testimony is a continuous thread which gives me some doubts.

Ms. Haire. Yes, but I have to point out that——

Mr. Scheuer. Would you like to join us at the table for a moment? Please come to the table if you want to make a remark.

This is Doris Haire.

Why don't you let Ms. Young finish and then we will let you make your observation.

Ms. Young. Fact 5. There is already such an alternative here in New York City. The Childbearing Center was planned with the express purpose of offering a safe, low-cost alternative to parents who wish an out of hospital birth. It is designed to test a solution to the real problem of the growing distrust of conventional obstetrical care.(5) This truly is a model that exemplifies the future direction for maternity care for healthy women and their families.

No proponents of a comprehensive health care program for mothers and children should overlook the significance of these facts and their impact on the implementation of title II, section 202(B). The denial of benefits to urban hospitals with fewer than 1,500 births and rural hospitals with fewer than 500 births, inevitably causing their demise, will sharply diminish the options to healthy maternity consumers and their families. The choice becomes then one between a large, overworked, possibly distant, certainly expensive, pathologically oriented, high risk center on the one hand and the familiar surroundings of their home on the other.

Unless safe, low-cost alternatives are actively developed by health providers at the same time, home births will increase, especially as their safety continues to be substantiated. Of greater concern is the possibility that uninformed parents who have received no health care and may be unsuitable candidates for home birth will reject conventional obstetrical care and safe alternatives altogether.

Section 202(B) in effect locks in the current expensive system of obstetrical care, and no studies show that the costs in these large, technologically oriented centers will decrease. It is likely that they will increase, in fact. Needless to say, for childbearing women who are at risk, and for the optimal management of an abnormal pregnancy, these centers are essential. But 90 to 95 percent of childbearing women are not high risk.

This bill not only fails to mention alternatives but it fails even to propose the testing of alternative maternity services—services that would be less costly to the taxpaying public. In fact, at the very time that families are looking for more choices, this bill proposes to take some of the existing ones away. We all know that when alternatives are provided people may choose and this, in turn, will stimulate competitive improvements in all alternatives?

Mr. Scheuer. Which choice would you say this bill threatens to take away?

Ms. Young. It does not offer any choice other than the possibility of home births which more and more professionals are beginning to involve themselves or participate in the attendance of on the one hand or with the regionalization program, what tend to be the high risk very large centers on the other hand. So you have these two extremes and we feel very strongly that it is in between alternatives such as I mentioned at the beginning—maternity homes, birthing rooms within hospitals, maternity apartments or maternity motel complexes adjacent to hospitals. We have to look at a lot further new alternatives that are just beginning to be thought about but they have to be tested. The Childbearing Center in New York City is a model that has to be looked at very carefully.

Mr. Scheuer. This is Mr. Jay Cutler who is administrative assistant to Senator Javits who will act in the Senator's absence.

Mr. Cutler. Could you help the committee by furnishing us with the criteria you believe would be appropriate for these low-cost alternatives? I am sure the last thing you would want to see us to do is just open the Pandora's box for anything to qualify for reimbursement?

Ms. Young. I don't quite understand. What criteria?

Mr. Scheuer. You talk about a motel next to a hospital.

Ms. Young. Yes.

Mr. Scheuer. I am very intrigued by your whole line of argument, it is very stimulating and very intriguing. What I think we are asking for is some detailed specifications. What would be the criteria, what would be the guidelines for a hospital who wanted to buy a motel.

Ms. Young. And build its own?

Mr. Scheuer. What would be the standards? For example, we know perfectly well it is crazy to take care of old elderly people who don't need intensive care in a hospital room that cost $100 or $125 a square foot and has oxygen tubes going through the wall. What elderly people need is the availability of medical care and what they find most desirable is a senior citizens home across the street from a hospital. They don't have to live in the hospital. You are giving a comparable argument for healthy births. A woman does not have to be in a hospital with oxygen in the wall and all of that as long as it is available. She can live in a simple apartment type or motel type complex.

Ms. YOUNG. Or a birth center.

Mr. SCHEUER. What we are asking for are some specifics. You have done a great deal of specifics on this. You speak with a great deal of authority in a very impressive way. Give us some specific centers. What kind of a birth center? What kind of a motel? What would be the physical standards of such a place and what would be the quality of care standards for the kind of professional or paraprofessional care that such a woman would have?

I think that we would not want to place any impediments in this bill for the kind of halfway house that you are talking about, something midway between the home and a tertiary hospital. We are simply asking for you to give us some help in this. We are very intrigued with the argument you present. If you would give us some kind of a memorandum and fine tune your thinking, we will hold the record open for that.

Ms. YOUNG. One of the speakers here today is Mrs. Ruth Watson Lubic who is the general director of the Childbearing Center which is the sort of halfway house or the alternative that we are talking about and she will be able to give you the specifics that you want.

Mr. SCHEUER. Fine.

Ms. YOUNG. May I finish?

Mr. SCHEUER. Yes.

Ms. YOUNG. Birth is a highly personal and joyful event, a family event. Often in the present obstetrical system high risk technology is routinely applied to the healthy childbearing woman and the needs of the family become secondary. Inherent in childbearing are emotional and social values that are especially significant for the establishment and maintenance of the family unit. Unfortunately the Maternal and Child Health Care Act has omitted any reference to the family, at least it did in the copy that I have. The health and safety of mother and baby can only be viewed within the total health care needs of the family.[1]

If hospitals don't satisfy the special needs of each family, even though they do satisfy some arbitrary number of births per year, they will be increasingly abandoned. Families will find their own solution when the options are so narrowed by the implementation of section 202(B), and they will find that solution whether or not health professionals want to participate in it and whether or not new health care programs anticipate and plan for it.

We believe that health providers must dedicate themselves to the combined task of improving the quality of the childbearing experience in existing obstetrical units and actively supporting the development of safe alternatives in maternity care, with the prime goal of insuring a healthy family and a healthy society at a reasonable cost.

---

[1] Klaus, M. H., and Kennell, J. H.: Parent to Infant Attachment. In Vaughan, V. C., and Brazelton, T. B., editors: The Family—Can It Be Saved? Chicago, 1976, Year Book Medical Publishers, Inc.

Mr. SCHEUER. Well, you have given us some very stimulating testimony that we will really chew on.

Ms. YOUNG. I have given you some more effects to that which I have attached to my written statement.

[Testimony resumes on p. 229.]

[The attachments referred to follow:]

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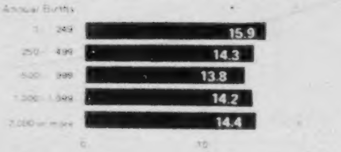
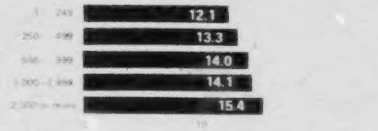
PERINATAL AND MATERNAL MORTALITY RATES BY SIZE OF HOSPITAL

STILLBORN RATE (per 1,000 births)

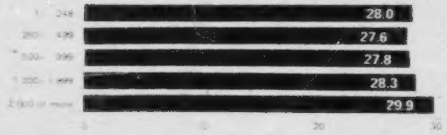


While the public is being advised by various health agencies of the value of eliminating small and medium sized obstetric services, a national survey by the American College of Obstetricians and Gynecologists reveals that, in general (and particularly in hospitals with 500 or more annual births) the larger obstetric services tend to have a greater incidence of infant and maternal deaths and that the stronger the affiliation between the obstetric service and a medical school the greater the rate of infant and maternal deaths. Undoubtedly some of these deaths result from the fact that there is a greater incidence of high-risk mothers in larger, teaching hospitals, but it is also possible that the greater tendency to intervene in the normal process of labor and birth in these institutions in order to provide teaching opportunities contributes to these statistics and may also result in a disproportionately high incidence of neurologically damaged children.

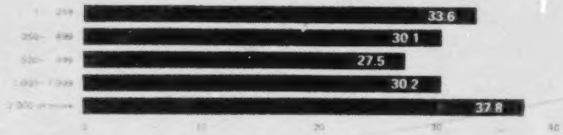
NEONATAL DEATH RATE (per 1,000 births)



PERINATAL DEATH RATE (per 1,000 births)



MATERNAL DEATH-RATE (per 100,000 births)



DEFINITIONS:

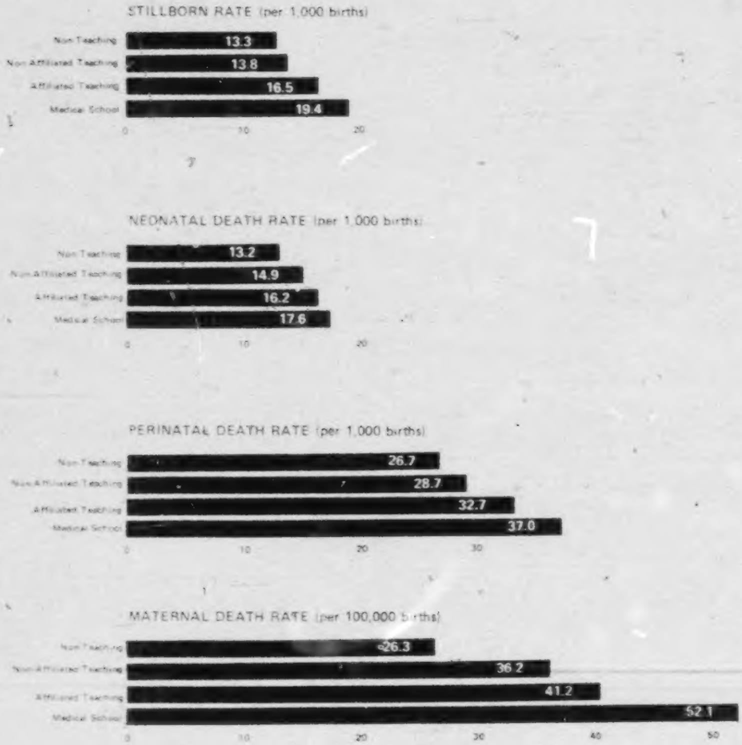
Stillborn—Fetus weighing 500 grams or more and born dead.
Neonatal Death—Death of a liveborn infant within the first 28 days of life.
Perinatal Death—Stillbirths plus Neonatal Deaths.

SOURCE:

National Study of Maternity Care: Survey of Obstetric Practice and Associated Services in Hospitals in the United States by the Committee on Maternal Health, The American College of Obstetricians and Gynecologists, 1970.

Prepared by: American Foundation for Maternal and Child Health, Inc., 30 Beekman Place, New York, N.Y. 10022

PERINATAL AND MATERNAL MORTALITY RATES BY TYPE OF HOSPITAL



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Prepared by: American Foundation for Maternal and Child Health, Inc., 30 Beekman Place, New York, N. Y. 10022.

NEUROLOGIC OUTCOME BY RACE

During the latter part of 1972 the Collaborative Perinatal Study, sponsored by the National Institute of Neurological Diseases and Stroke, issued its first major report entitled THE WOMEN AND THEIR PREGNANCIES, published by W. Saunders and Co., Philadelphia. The Study, which followed over 50,000 infants from birth to one year of age, brought out some facts which were surprising to many, for when they compared the incidence of significant neurologic damage in the children at one year of age, there was a slightly greater incidence of neurologic damage among white children than among black children of the same age (17.26 and 16.00 per thousand respectively). See Fig. 1.

Figure 1. COLLABORATIVE PERINATAL STUDY
NATIONAL INSTITUTE OF NEUROLOGIC DISEASES AND BLINDNESS

Neurologic Outcome by Race	White			Negro		
Outcomes	No. of Cases	Number	Rate per 1,000	No. of Cases	Number	Rate per 1,000
Births	19,048			20,167		
Perinatal Deaths		668	35.07		845	41.90
Stillbirths		415	21.79		457	22.66
Fresh Stillbirths		200	10.50		246	12.20
Live Births	18,633			19,710		
Neonatal Deaths		253	13.58		388	19.69
Live Births with Known Birth Weight	18,481*			19,504**		
Birth Weight Under 2501 gm		1,319	71.37		2,617	134.18
One Year Exams	14,662			17,123		
Neurologically Abnormal at 1 Yr.		253	17.26		274	16.00

* Mean Birth Weight: 3,273 gm
** Mean Birth Weight: 3,039 gm

The following statement, made on pages 39 and 40 of WOMEN AND THEIR PREGNANCIES, by Niswander and Gordon, authors of the report, indicate their surprise at the findings.

> "Included among the children classified as neurologically abnormal at the one-year-examination are those with definite signs of organic impairment; for example, definite hemiparesis. Excluded are those children who, on the basis of 'soft' signs, were suspect of being abnormal. It is unexpected and fascinating to find no meaningful difference between Whites and Negroes with respect to the rates of definite neurologic abnormality observed at one year, though there are some differences in the rates reported from Center to Center. The failure to find a difference by race is unexpected because of the known relationship between low birth weight and neurologic abnormality." (underscoring by author DBH)

These findings are not so startling when one considers that, although the incidence of low-birth-weight, prematurity and undernutrition is decidedly greater among our black population, black patients, who are more often clinic patients, traditionally receive less medication during labor and birth. (In one New York City hospital during 1970 there was twice the incidence of depressed newborn babies among private patients as among clinic patients.)

INFANT MORTALITY RATES FOR LOWEST 20 COUNTRIES WITH POPULATIONS OVER 2,500,000

Country	1972	1973
Sweden	10.8	9.6
Finland	11.3	10.0
Japan	11.7	11.3
Netherlands	11.7	11.5
Denmark	12.2	11.5
Norway	11.3*	11.8*
Switzerland	13.3	13.2*
France	16.0	15.5*
Canada	17.1	15.6
German Democratic Republic	17.7	16.0
New Zealand	15.6*	16.2*
Australia	16.7	16.5*
Hong Kong	17.5	16.8*
England and Wales	17.2	16.9
Belgium	18.9	17.0*
United States	18.5	17.7
Ireland	17.8	18.0
Czechoslovakia	21.4	21.2
German Federal Republic	22.4	22.7
Israel	24.2	22.8

* Provisional

Source: Wegman, M.: "Annual Survey of Vital Statistics - 1974", Pediatrics, 56: 960-966, December 1975.

THE PREGNANT PATIENT'S BILL OF RIGHTS

American parents are becoming increasingly aware that well-intentioned health professionals do not always have scientific data to support common American obstetrical practices and that many of these practices are carried out primarily because they are part of medical and hospital tradition. In the last forty years many artificial practices have been introduced which have changed childbirth from a physiological event to a very complicated medical procedure in which all kinds of drugs are used and procedures carried out, sometimes unnecessarily, and many of them potentially damaging for the baby and even for the mother. A growing body of research makes it alarmingly clear that every aspect of traditional American hospital care during labor and delivery must now be questioned as to its possible effect on the future well-being of both the obstetric patient and her unborn child.

One in every 35 children born in the United States today will eventually be diagnosed as retarded; in 75% of these cases there is no familial or genetic predisposing factor. One in every 10 to 17 children has been found to have some form of brain dysfunction or learning disability requiring special tr[illegible]ment. Such statistics are not confined to the lower socioeconomic group but cut across all se[illegible]s of American society.

New concerns are being raised by childbearing women because no one knows what degree of oxygen depletion, head compression, or traction by forceps the unborn or newborn infant can tolerate before that child sustains permanent brain damage or dysfunction. The recent findings regarding the cancer-related drug diethylstilbestrol have alerted the public to the fact that neither the approval of a drug by the U.S. Food and Drug Administration nor the fact that a drug is prescribed by a physician serves as a guarantee that a drug or medication is safe for the mother or her unborn child. In fact, the American Academy of Pediatrics' Committee on Drugs has recently stated that there is no drug, whether prescription or over-the-counter remedy, which has been proven safe for the unborn child.

The Pregnant Patient has the right to participate in decisions involving her well-being and that of her unborn child, unless there is a clearcut medical emergency that prevents her participation. In addition to the rights set forth in the American Hospital Association's "Patient's Bill of Rights," (which has also been adopted by the New York City Department of Health) the Pregnant Patient, because she represents TWO patients rather than one, should be recognized as having the additional rights listed below.

1. *The Pregnant Patient has the right,* prior to the administration of any drug or procedure, to be informed by the health professional caring for her of any potential direct or indirect effects, risks or hazards to herself or her unborn or newborn infant which may result from the use of a drug or procedure prescribed for or administered to her during pregnancy, labor, birth or lactation.

2. *The Pregnant Patient has the right,* prior to the proposed therapy, to be informed, not only of the benefits, risks and hazards of the proposed therapy but also of known alternative therapy, such as available childbirth education classes which could help to prepare the Pregnant Patient physically and mentally to cope with the discomfort or stress of pregnancy and the experience of childbirth, thereby reducing or eliminating her need for drugs and obstetric intervention. She should be offered such information early in her pregnancy in order that she may make a reasoned decision.

3. *The Pregnant Patient has the right,* prior to the administration of any drug, to be informed by the health professional who is prescribing or administering the drug to her that any drug which she receives during pregnancy, labor and birth, no matter how or when the drug is taken or administered, may adversely affect her unborn baby, directly or indirectly, and that there is no drug or chemical which has been proven safe for the unborn child.

4. *The Pregnant Patient has the right* if Cesarean section is anticipated, to be informed prior to the administration of any drug, and preferably prior to her hospitalization, that minimizing her and, in turn, her baby's intake of nonessential pre-operative medicine will benefit her baby.

5 *The Pregnant Patient has the right*, prior to the administration of a drug or procedure, to be informed of the areas of uncertainty if there is NO properly controlled follow-up research which has established the safety of the drug or procedure with regard to its direct and/or indirect effects on the physiological, mental and neurological development of the child exposed, via the mother, to the drug or procedure during pregnancy, labor, birth or lactation—(this would apply to virtually all drugs and the vast majority of obstetric procedures).

6 *The Pregnant Patient has the right*, prior to the administration of any drug, to be informed of the brand name and generic name of the drug in order that she may advise the health professional of any past adverse reaction to the drug.

7 *The Pregnant Patient has the right* to determine for herself, without pressure from her attendant, whether she will accept the risks inherent in the proposed therapy or refuse a drug or procedure.

8 *The Pregnant Patient has the right* to know the name and qualifications of the individual administering a medication or procedure to her during labor or birth.

9 *The Pregnant Patient has the right* to be informed, prior to the administration of any procedure, whether that procedure is being administered to her for her or her baby's benefit (medically indicated) or as an elective procedure (for convenience, teaching purposes or research).

10 *The Pregnant Patient has the right* to be accompanied during the stress of labor and birth by someone she cares for, and to whom she looks for emotional comfort and encouragement.

11 *The Pregnant Patient has the right after appropriate medical consultation* to choose a position for labor and for birth which is least stressful to her baby and to herself.

12 *The Obstetric Patient has the right* to have her baby cared for at her bedside if her baby is normal, and to feed her baby according to her baby's needs rather than according to the hospital regimen.

13 *The Obstetric Patient has the right* to be informed in writing of the name of the person who actually delivered her baby and the professional qualifications of that person. This information should also be on the birth certificate.

14 *The Obstetric Patient has the right* to be informed if there is any known or indicated aspect of her or her baby's care or condition which may cause her or her baby later difficulty or problems.

15 *The Obstetric Patient has the right* to have her and her baby's hospital medical records complete, accurate and legible and to have their records, including Nurses' Notes, retained by the hospital until the child reaches at least the age of majority, or, alternatively, to have the records offered to her before they are destroyed.

16 *The Obstetric Patient*, both during and after her hospital stay, has the right to have access to her complete hospital medical records, including Nurses' Notes, and to receive a copy upon payment of a reasonable fee and without incurring the expense of retaining an attorney.

It is the obstetric patient and her baby, not the health professional, who must sustain any trauma or injury resulting from the use of a drug or obstetric procedure. The observation of the rights listed above will not only permit the obstetric patient to participate in the decisions involving her and her baby's health care, but will help to protect the health professional and the hospital against litigation arising from resentment or misunderstanding on the part of the mother.

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Mr. SCHEUER. If you want to give us a further statement on some specifications or guidelines or however you choose to describe them, simply a refined description of these places that you describe, both the physical characteristics and the kind of services that should be provided and by whom, we would be very grateful. I do want to say we have made a passing stab at making things easier for the family, as you can see on page 21 of the bill where we say that there shall be no restrictions on visting hours for parents and guardians except as medically required.

On line 18 on page 21 we read that the board may wave the required numbers of deliveries that you referred to before if it finds it in the best interests of the medical care of pregnant women in an area.

I quite agree with you that the family has a role. You didn't specifically address the fathers and the way they are demeaned and humiliated and destroyed as human personalities by tertiary hospitals, and if you find that I seem to be permanently wounded and traumatized it is because as a father I was subjected to this humiliating treatment that you describe four separate times.

Ms. YOUNG. Have you?

Mr. SCHEUER. Yes. I am sure I have not recovered from the experience.

Ms. YOUNG. At this time there are choices and alternatives.

Mr. SCHEUER. I am sorry that your testimony came a generation too late for me.

Ms. YOUNG. I am sorry, too.

Ms. LUBIC. It is never too late.

Mr. SCHEUER. My wife should hear that.

Ms. LUBIC. For her it may be too late.

STATEMENT OF BARBARA SEAMAN

Ms. SEAMAN. I am Barbara Seaman. This seems to me to be a fine and humane piece of legislation. As a mother, and a patient, and a wife of a father who was also traumatized by our experiences, despite the fact, incidentally, that he is a physician and was not allowed in the labor room and so on, I want to——

Mr. SCHEUER. He was not allowed in?

Ms. SEAMAN. He was not allowed in the labor room. In fact, the obstetrician said, "You might faint." He said, "Well. I have delivered many babies." The obtetrician said, "It is different if it is your own." The truth is they don't want anybody to see any mistakes they make. That is the main reason for excluding families from the delivery room. It is not germs and things like that. I do want to thank you.

Mr. SCHEUER. I was the author of the new careers program which placed paraprofessionals in the schoolroom as assistants to the licensed teacher. In the very early stages of the program there was enormous opposition to this program from teachers who were very reluctant to have another adult in the room looking over their shoulder even though that adult was certainly not an inspector general, it was a lady from the neighborhood who had a few months of training. Even though. they felt threatened. Now after a decade of experience with a neighborhood paraprofessional as a teaching assistant they have overcome their reluctance and they have found the neighborhood paraprofessional a very, very useful tool and they have even gone on strike or threatened to go on strike on their behalf.

As you have suggested, the doctors who feared having another person in the delivery room watching them, compares to the early days of the paraprofessional programs for teacher aides and teacher assistants when there was enormous reluctance on the part of the teacher having another adult watching their work, so what you say reflects the human condition.

Ms. SEAMAN. Yes; it is a very common situation. In contrast to Dr. Pomrinse and Dr. Ziskin, I was overwhelmed and elated that there is so much consumer input on your governing boards and I hope you will remain unswervable.

Mr. SCHEUER. We are unswervably openminded.

Seriously, we are here today—and I probably should have said this in the beginning. We didn't write this bill in stone, but it represents our best thinking up to now. We are sure that these hearings are going to produce many constructive suggestions. We certainly got a load of stimulating reactions from your predecessor, Ms. Young. We are openminded. We have certain guiding principles that have moved us to this point. A feeling that health care can be on a prepaid basis and that there should be options, a feeling that health care for mothers and kids should be universally available, a feeling that health care for mothers and kids should be slanted toward preventive health care and not sickness care and tertiary hospital care. These are underlying philosophies that I think you would agree with, but in terms of specifics and in terms of elaboration we are getting a lot of help today from Ms. Young and from [illegible] and we are openminded.

Ms. SEAMAN. The one thing that I feel is missing from the bill, the one major point that I would like to call to your attention, is the issue of informed consent which is of very great concern to me and to most people in the women's movement, and in the consumer health movement. A woman giving birth is not a sick person. She is capable of making her own decisions concerning many aspects of pregnancy and delivery and she should be encouraged to.

Obstetricians have been giving unnecessary drugs, including for example our latest terrible tragedy, the fact that DES is causing cancer in the sons and daughters of women who were given it 20 years ago. Many people are not aware that DES was never shown to work to prevent miscarriages, No. 1, and No. 2, that there were animal studies going back to the 1930's which showed exactly the same effects. If you give DES to pregnant mice, the female offspring get a rare form of vaginal cancer and the sons are sterile. Yet, its use was pushed ahead because of what I can only construe as some fantasy of certain Harvard obstetricians.

Oddly enough, poor women receiving minimal obstetrics care have had the advantage of escaping some of the dangers of overintervention that the middle class and upper class have been subjected to. I believe the Carnegie Foundation has found certain types of problems associated with pregnancy and delivery in the poorer section and others in more affluent women.

Mr. SCHEUER. What kinds of problems?

Ms. SEAMAN. Well, and this is also based on NIH studies, from the overuse of anesthesia and induction, diet pills during pregnancy, thyroid, diuretics—they are really dangerous. I will get to that in a minute. The fact is that no drug has been proven safe for a pregnant woman and yet many obstetricians are still cavalier or even promiscuous in their prescription of powerful medication. I believe that they have an inferiority complex of some sort. You know other doctors make fun of them and they say that baby catching is an easy speciality. I spent 20 years trying to analyze this.

I was a child care editor of a leading women's magazine for many years. I believe that they have to prove they are real doctors. Since 95 percent of deliveries are where things are going on normally, there is really not much that is needed to be done. I think they get frustrated so they have to add a little excitement and so on. I don't think their motives are evil but they have done an enormous amount of damage because of wanting to feel like they are real doctors.

Mr. Scheuer. This has been a very interesting morning.

Ms. Seaman. Well, I am sure your own family has had experiences like this. I mean one of my daughters was induced for no reason other than that my obstetrician was getting married and going on a cruise. In fact, I wrote a piece in the New York Times about this—I don't know if you recall it. As a matter of fact, that daughter did have dyslexia. There is a very important study that I think has been badly neglected, the NIH study.

Mr. Scheuer. You mean the infant that was born as a result of induction?

Ms. Seaman. Yes. She had a reading disability. The evidence is not conclusive but this seems to be associated with induction of labor.

Mr. Scheuer. So there was a cause and a direct relation?

Ms. Seaman. I am not saying it has been proven but it occurs much more frequently in children where these labor inducing drugs have been used, particularly where there is not any other factor. In our case I was well nourished and had all the good socioeconomic advantages. There is a very good study by the NIH, it is called "The Women and Their Pregnancies," published by Saunders. They followed up years of induced babies and there does appear to be a connection. Many obstetricians are not aware of this because in point of fact the use of these drugs is rising constantly in the United States, it is going up each year.

Mr. Scheuer. Apart from any comparably rising indication of need to induce labor medically.

Ms. Seaman. The doctor wanted to get to his 4 o'clock golf game or call his broker before the stock market closes. It gets them out of the delivery room faster. Of course there are some cases where it is needed. Dr. Caldyro-Barcia whom a previous witness quoted is a very great research obstetrician and president of the International Gynecologist Association. He has estimated that no more than 3 to 5 percent of deliveries require the intervention of these drugs that speed up the delivery.

Mr. Scheuer. What percent?

Ms. Seaman. Forty to fifty percent of the deliveries that now take place in American hospitals use these drugs.

Mr. Scheuer. Ten to fifteen times the number necessary?

Ms. Seaman. Yes. For years doctors were pushing this childbirth by appointment, it would be so nice if you come in and we will give you the drug. Women have learned to be wary of that and fewer and fewer women want it so the amount of childbirth by appointment is dropping. However, once she is in the delivery room she does not know what they are sticking in her arm. In most instances where these drugs are used it is not with the informed consent of the patient at all, it is just used to speed the labor and delivery along.

This brings me to my central point. I want to strongly urge that you put a provision in your bill concerning informed consent which would say something to the effect that no medication or surgery should be prescribed except of course under emergency conditions unless it has been fully discussed with the patient and the risks and the pertinent areas of uncertainty as well as the benefits are all explained to her. This would be a most forward looking provision for there is a great concern about informed consent at all quarters of health care.

Even magazines as conventional as McCall's and Family Circle are constantly running articles on topics like "Why Women Don't Love Their Gynecologists Any More" which state over and over they don't wish to be treated in an authoritarian way. There are a lot of films circulating in women's groups that are popular, like "Taking Our Bodies Back." Certainly if this were the first health bill to include clear provisions concerning informed consent and the right of patients to participate in their own decisions, I think it would be a very memorable and important sort of provision.

I would like to point out that even the FDA has finally in 1970 for the first time started including some birth control pill information on the package. They have done a study of that recently to see whether people read the label and not only did they find that 85 percent of the women who take the pill read it but most all of them said they wish it were much, much longer, they want much more detailed information than they are getting. FDA is now revising the insert to make it much longer.

So surely in this whole area of chilbirth where there are so many options, and so many ways of managing delivery, it should be up to the mother to decide. It is her body and it is her baby. If she would rather have more intense pain for a little while but not risk the possibility that it will be harder to resuscitate her baby later, it is up to her because if she has a brain damaged child she is the one that has to take care of it, not the obstetrician who delivered it. Incidentally, these drugs that are used to speed up labor or induce labor not only cause brain damage in some of the children but also occasionally cause uterine rupture and death to the mother so it is quite a serious risk for her.

Now just two other areas that I would like to mention in passing are the drugs that are used to dry up breast milk that they give out in hospitals.

Mr. SCHEUER. Let me say before you move on to another subject that I have just introduced a consumer information provision in the new FDA drug bill that will do almost exactly what you are talking about. I will send it to you.

Ms. SEAMAN. I would like to see it very much, and hope you apply similar principles to this bill, too.

Mr. SCHEUER. Indeed.

Ms. SEAMAN. The two other areas that occur to me, one was called to my attention by Mrs. Haire, but also I am very interested in hormones which I have been covering as a reporter for 20 years. They give women who decline to breastfeed in American hospitals, very high doses of hormones, the purpose of which is to dry up the breast milk. Now as a result of these high doses of hormones, their rate of postpartum blood clots has tripled; that is to say, that there is actually a greater number of deaths, three times the number of deaths among women who don't breast feed in American hospitals simply because of these hormones that are given to them. There are other side effects, too, like occasional masculination and moustaches and so on, but on top of this these products don't ultimately work. A great many women find they only work for the few days they are in the hospital; when they get home and the effects of the hormones wear off the breast milk comes in anyway, and they still have pain and they have to bind their breast.

The whole purpose of those hormones, which are life threatening, is really just to keep the women off the doctors' and nursing staffs' back so that they won't have to be giving icepacks to the mother who is not breast feeding or tapering her off gradually. To me it is an extremely scandalous situation. The worst part is that we have interviewed several hundred women on this subject and we have found that none of them have been told that they were getting hormones, they are never told what it is they are getting.

They come around and they give them a little thing with a bunch of pills in it and they say, "Here, take this," or they come around with a needle and they give them a shot. The average hospital, if the mother says, "What is this?" she is told to shut up. The nurse is not allowed to tell her, the doctor does not want to tell her. Once in a while you find someone who will explain it, but it is rare. Most of the women I have interviewed would rather taper off. There are methods used in Scandinavia, which actually Mrs. Haire could tell you about, but there are much safer ways than taking those powerful hormones that cause blood clots.

I want to mention circumcision. The American Academy of Pediatricians has twice said that circumcision should not be peformed routinely, the complication rate is much higher than had been thought. Yet 90 percent of newborn boys in the United States are still circumcised often without specific consent of their parents. In fact, a study at Columbus, Ohio, revealed that something like, I think, 65 percent of the mothers whose sons had been circumcised had never even been approached about it, nobody had discussed it or asked, "Do you want your son circumcised?" Certainly nobody told them of the risks of infection, mutilation, and so on, or occasional deaths. The situation is so bad that in the Journal of the American Medical Association Dr. William Keith C. Morgan stated—

> Any recently delivered mother who is eccentric enough to wish her child to retain his foreskin would be well advised to maintain permanent guard over it until they both leave the hospital.

Now I have only given three or four examples and others will give other examples but you in your own lives have had such experiences and I just feel that our ever-growing hospital medical establishment should not have any more medical funds. I don't want to give them another penny of any taxpayers money unless there are informed consent procedures built into every step of the way.

Thank you.

Mr. SCHEUER. Well, your testimony has been remarkably interesting. Do you have any questions?

Mr. CUTLER. No.

Mr. SCHEUER. I think we had a very informal colloquy along the line so with thanks to you we will move to the next witness.

Ms. Haire.

STATEMENT OF DORIS HAIRE, PRESIDENT, AMERICAN FOUNDATION FOR MATERNAL AND CHILD HEALTH

Ms. HAIRE. I am Doris Haire. I am the past president of the International Childbirth Education Association. I am presently the president of the American Foundation for Maternal and Child Health. I am a medical sociologist and I have been to 36 countries to observe obstetric care in order to make a comparative analysis.

I might say that recently I heard Dr. Charles Lowe, who is Special Assistant to the Secretary of Health for Pediatric Affairs, say that 75 percent of all medicine is based on folklore, and when I said this to Dr. Emanual Friedman, who is professor of obstetrics at Harvard, he said, "Oh, Mrs. Haire, 95 percent of medicine is based on folklore."

Mr. SCHEUER. We are going to have to redo the arithmetic. I have been told recently that it was only at the turn of the century that an individual having an encounter with a member of the medical profession, had an even-steven or better chance that the encounter would produce more good than harm.

Ms. SEAMAN. It was World War I. It was even later than that.

Mr. SCHEUER. Now you are telling me that we have not reached that point yet.

Ms. HAIRE. I am only quoting.

Mr. SCHEUER. I am only quoting.

Ms. HAIRE. This is a letter to Senator Javits, and I would like to read it.

Mr. SCHEUER. If there are no objections, the letter will be put in the record at this point and reproduced in its entirety.

Ms. HAIRE. All right.

[The letter follows:]

WAISMAN CENTER
ON MENTAL RETARDATION AND HUMAN DEVELOPMENT,
INFANT DEVELOPMENT SECTION,
Madison, Wis., August 27, 1976.

MARGARET HAGGERTY, M.D.,
% Senator JACOB JAVITS,
Suite 321,
Russel Building,
U.S. Senate,
Washington, D.C.

DEAR DR. HAGGERTY: I have recently learned from Doris Haire that you were the legislative consultant on Senator Javits' maternal and child health insurance bill (S. 3593). I am interested in learning the rationale for recommending that coverage only be provided for hospitals performing 1500 or more deliveries yearly in urban areas and five hundred deliveries or more in rural areas. I do not know of any data supporting the contention that the more deliveries a unit performs, the better their maternal and infant outcome.

We have currently been involved in conducting medical and behavior developmental outcome studies of home delivery, and I am sending you copies of our research reports. Our most recent and best study is entitld "Home versus Hospital Delivery: Comparisons of Matched Populations" and is enclosed. We compared by means of retrospective chart review 1046 matched (case by case) home and hospital deliveries (for age, parity, length of gestation, major risk factors, education, socioeconomic status, and total risk factor score on the Nova Scotia

> Screening Criteria. Enclosed is a preliminary copy describing the results. The Hospital group (all born in hospitals performing over 1500 deliveries yearly with regional neonatal and maternal intensive care units) had more intra-uterine fetal distress, more birth injuries, more infants with low Apgar scores and infants needing resuscitation, more full term infants with respiratory distress last more than 12 hours, more neonatal infection, and equivalent outcomes in other respects. If home delivery outcomes can be this much better than such a hospital that would be funded under Senator Javits' bill, we wonder if simply assuring quantity will assure quality. It would seem also that this requirement ignores most parents' preference for a smaller, more personalized obstetrical unit. Dr. Halverkamp has shown somewhat improved outcome of high risk patients monitored by a nurse as opposed to a fetal monitor with much greater patient satisfaction with the nurse. It would seem that an optimal sized unit would be one that provides the capability for one-to-one nursing or monitrice care. Finally, given the excellent results of home delivery services and maternity centers, it would seem logical to include these alternatives as services covered. Given this, it would make more sense to me to set a minimum outcome which any service hoping to be covered by Federal money would have to surpass.
>
> I would enjoy learning your reaction to this and look forward to your reply. Under separate cover I will send you our other home birth studies.
>
> Yours,
>
> Lewis E. Mehl, M.D.

Mr. Scheuer. You wanted to read something?

Ms. Haire. This is a letter from Dr. Lewis E. Mehl to Senator Javits:

> We compared by means of retrospective chart review 1,046 matched (case-by-case) home and hospital deliveries (for age, parity, length of gestation, major risk factors, education, socioeconomic status, and total risk factor scope on the Nova Scotia screening criteria). Enclosed is a preliminary copy describing the results. The hospital group (all born in hospitals performing over 1,500 deliveries yearly with regional neonatal and maternal intensive care units) had more intrauterine fetal distress, more birth injuries, more infants with low Apgar scores and infants needing resuscitation, more full-term infants with respiratory distress lasting more than 12 hours, more neonatal infection——

And then other data.

Now I would like to——

Mr. Scheuer. We are getting back to the same logical question that we have discussed at length with Ms. Young.

Ms. Haire. Really what I am saying is——

From the Floor. She just indicated the two low-risk groups were matched populations. It is not the same thing.

Ms. Haire. Even so, I think that before we are boxed into a situation—I know that you have made room for exceptions, but exceptions are very difficult to bring about. We have seen this with the maternity center. Anyway, I would like to see scientific evidence produced by HEW which shows that care in an institution of 1,500 or more births a year is safer. You know, it really should be the shoe on the other foot. HEW must have this data if it is available. Now, I checked with several institutions and several agencies and I cannot find a single agency in the country that can give us a single scientific fact that an institution with 1,500 or more births in a year would actually be safer.

Mr. Scheuer. Safer than what?

Ms. Haire. Than babies born in a smaller institution.

Mr. Scheuer. Or at home?

Ms. Haire. Yes. Ted Quillian, who is a famous obstetrician, said at a meeting that I just attended in California yesterday on perinatal asphyxiation and brain development, that there is no data to show that an obstetric service of 1,500 births a year is safer. He felt that rather than giving a specific number, the hospital should be evaluated on quality, not quantity, and that as far as he was concerned to say 500 or more births a year would be acceptable to him.

I would like to see that in this bill because I think it is terribly important in my area. For the last few years there has been informed consent but I would like to see the Maternal and Child Care Act include directives which would assure that:

1. Neither mothers nor their children will be used as research or teaching subjects unless they are so advised—in writing as well as verbally—and that the right to considerate and quality care in that institution not be based on the patient's agreement to be used as a teaching or research subject.

2. Expectant and childbearing women are advised, prior to treatment, of the known risks which may result from the proposed treatment and of the areas of uncertainty regarding the long-term or delayed effects of the treatment.

3. The chairman of every institutional review board be licensed by the State, registered with the FDA, the county and the State medical boards and the State and Federal offices of consumer affairs, where the information will be available to the public.

I don't know whether you have read the GAO report that showed that informed consent was missing in almost 85 percent of the research projects.

Mr. Scheuer. On all research projects?

Ms. Haire. He said when you really look—I have a copy and I can send you one.

Mr. Cutler. He testified before the Senate Health Subcommittee on this precise issue and the question is while 85 percent may not be perfect, the informed consent issue arose really as to what portions were not provided within the informed consent. Was it a technical matter of a date being dropped or something like that?

Ms. Haire. Actually, if the chairman were registered with the Office of Consumer Affairs it would make that information much more available to the public because it is almost impossible to get this information out of the government complex. This is very important to me and I think to most women who are becoming very informed about health care in this country. The bill should require a complete copy of the mother's prenatal and intranatal records, including nurses' notes, to be attached and preserved with the baby's record until adulthood.

Lastly, I think that every birth record in this country should have the "Time to Sustained Respiration" on that birth record because the American birth study and the British birth study of 1970 had both shown that a delay in respiration is critical or can be critical, not merely to the life of the child but to his neurologic intactness. That is information that we must have if we are to really begin to look at what causes our neurologic problems in children. Obviously delay in respiration is not the only cause but two major studies have shown it to be important and this information is missing on most birth records. We should have a place to record the "Time to Sustained Respiration." With that information it is a whole different ball game.

Thank you.

Mr. Scheuer. Thank you very, very much.

We will now hear Ms. Ruth Watson Lubic.

STATEMENT OF RUTH WATSON LUBIC, ON BEHALF OF THE MATERNITY CENTER ASSOCIATION

Ms. Lubic. I am a real nurse-midwife. I may not be a real obstetrician.

I am appreciative of the opportunity to come and share with you the thinking of the Maternity Center Association. Primarily, I would like to invite you, Representative Scheuer, and Jay Cutler and any of the staff to come and see the childbearing center while you are in New York. It is at 48 East 92d Street. Our agency is going to be 60 years old next year; Frances Perkins was our first general director. One of our major activities has been to improve maternity care through demonstration projects. The first school of nurse-widewifery was one of those demonstrations. Prenatal care was another.

We have also been very involved in parent education, both for childbearing and for parenting. We attempt to answer needs expressed by the public.

Ms. Young was talking about families opting out because of their disenchantment with hospital care. We are convinced that this is the case and that it is a widespread phenomenon. We opened the childbearing center after having gone through an elaborate procedure with the State of New York to insure that we were doing this in as safe a manner as possible, because we were the first of a kind. I might say that we have had remarkable opposition from some groups in organized medicine, the New York City Department of Health, obstetricians, and others.

Mr. Scheuer. In what form did that show itself?

Ms. Lubic. Oh, many forms. I think probably the most outstanding is the feeling of obstetrician-gynecologists against out-of-hospital birth. We have implored groups of obstetricians as well as professional organizations and individuals to please present us with evidence that what we are trying to demonstrate is unsafe—if in fact it could be shown to be unsafe a priori—because we are not an agency that has been in business to hurt mothers and babies.

Mr. Scheuer. You say the city department of health——

Ms. Lubic. Has denied us a medicaid number so we cannot get reimbursement for medicaid-eligible families.

Mr. Scheuer. Did they give you any reasons?

Ms. Lubic. Generally the reason given is safety, although there is no existing evidence that we are unsafe, and we are, in fact, trying to test the safety of this particular form of care. I think recently the city claimed that the medicaid law itself would militate against the experimental nature of our unit. This was turned down by the State of New York, and my last information was that Doctor Toff, who is the assistant commissioner downstate, had ordered the city to go ahead and give us a medicaid vendor number. Perhaps Doctor Mayer can testify on that later.

Mr. Scheuer. Off the record.

[Discussion off the record.]

Mr. Scheuer. Would Dr. Mayer join us here for a moment.

Dr. Mayer. I would be pleased to.

Mr. Scheuer. You are associated with Dr. Bellin?

Dr. Mayer. Yes, as deputy commissioner of professional standards and review for the New York City Health Department.

Mr. Scheuer. Can you give us some inside information as to why the city health department has taken this jaundiced view toward home births and alternatives to tertiary hospital births?

Dr. Mayer. Yes; I believe I can. I think that Mrs. Lubic has given you some of the indications. While we appreciate the work that the Maternity Center Association has done heretofore, the efforts in which it is now engaged is largely experimental. The city health department is not alone in its feeling that to return to deliveries out of a hospital situation with its known precautions for safety, is counter to the interests of the safety of women. We are endeavoring to regionalize perinatal care with tertiary centers serving that as referral resources to both primary and secondary level facilities so women have access to the best care available. Primary level facilities having competence to handle uncomplicated deliveries need a volume of approximately 1,500 deliveries annually; the maternity center does not meet this definition.

Mr. Scheuer. Let me interrupt you there. Is this for reasons of cost or is this for reasons of safety?

Dr. Mayer. This is for reasons of safety.

Mr. Scheuer. Is there not a population group among pregnant women that you could define as a population group that does not need all the highly technical devices and systems that are available in a tertiary hospital?

Dr. Mayer. I don't know how familiar you are with the processes of obstetrics and birth.

Mr. Scheuer. I am one of five kids and we were all born at home. We all turned out to be fine.

Dr. Mayer. There are some patients who are certainly low risk but there is nobody who can predict at what point a delivery will develop a complication. Prolapse of the cord may occur, or a baby can be born with the cord looped several times around its neck, there can be hemorrhage at the last minute. I am sure Mrs. Lubic will agree there are such situations which can't be diagnosed far in advance of the actual delivery. These all require the backup of a full hospital setting with all of the safeguards for the life support systems.

Mrs. Lubic has acknowledged this certainly in endeavoring to have a backup hospital for transfer of the patient. I do not know where the backup hospital arrangements now stand. There was a backup agreement but the health department is concerned about the patients who were transferred. The city is trying to establish with the State health department what the experience of the maternity center is.

Mr. Scheuer. Were you here when Mrs. Barbara Seaman testified?

Dr. Mayer. Yes; not through her entire testimony. I was sitting on the side. I came in while she was talking.

Mr. Scheuer. Do you feel that for any woman home delivery is desirable?

Dr. Mayer. I would think that in a situation where there was no better institutional service a home delivery, if attended by appropriately trained persons, could be safe. I will not go so far as to say that is desirable.

Mr. Scheuer. Let's take a middle-class family at the present time or upper middle-class family that could afford a tertiary hospital.

Dr. Mayer. With an obstetrician in attendance?

Mr. Scheuer. Yes.

Dr. Mayer. The queens of England and other queens have done it that way for years.

Mr. Scheuer. That does not prove it right.

Ms. Lubic. If it is safe for the queen of England, why is it not safe for the mothers and babies of New York? I think one of the concerns has been that we are 11 minutes from the backup. The question really relates to this: Can you detect incipient problems in time to get the mother to a proper level of care?

Mr. Scheuer. We have just heard that 60 percent, I think, of all complications could not be detected in advance.

Ms. Lubic. He said 60 percent of women could be noted to be low risk and then 40 percent you cannot tell.

Mr. Scheuer. Correct. Now of that 40 percent, what percentage of those problems that arose would arise in time to get that woman from her home to the hospital facility in time?

Ms. Lubic. Representative Scheuer, I think that is what we are interested in finding out, because there are no real data on this. There are data on home delivery services. Our agency operated one for 28 years, and our results compared very favorably with those of New York City as a whole. This can be found in the literature.

The Frontier Nursing Service managed 18,000 births at home in the Appalachian area before it went to a hospital setting, and I have some interesting information about what that shift did to their preventive services and also to their costs. They were doing home births in a setting of rural poor people in Appalachia, when the nearest hospital was 40 miles away and roads were primitive. Women had to be taken out on horseback or wagons or whatever, and at that point in time they had a maternal mortality which was one-third the rate of the country as a whole. Now these were women that would be considered high risk by all definitions today, because they were poorly educated, poorly nourished, and lived in the hills of Appalachia.

We are not interested in saying that there is only one way for women to have their babies; we are not trying to take births out of the hospital. We are trying to bring into the childbearing center couples who were planning do-it-yourself home delivery.

We are trying to meet a public health problem. I think the whole thing has been turned around so it looks like we are trying to take people out of the hospital. We are not. We are trying to see if this is safe for a carefully screened population. We are keeping very careful records. We are being very careful about our screening criteria. We don't know if it is going to be safe or unsafe.

We feel we at least deserve the opportunity to find out, but the opposition to us has been such that the State has even been pressured to take away our operating certificate at this point so that we cannot operate further, largely on the basis of the claim that our operation is unsafe. We await data; to make a priori decisions is useless. I could tell you stories or give you anecdotal evidence about things that have happened in home births because there have been hemorrhages. I could give you anecdotal evidence about hospitals where women have had similar experiences, for this or that reason.

I don't think the issue is where it belongs. The issue is can we provide safe, satisfying, and economic care for a carefully selected population and can we demonstrate whether this is so. The population that comes to us is not driven to us; we don't randomly select women coming into a hospital clinic and say, "You go here, you go there." We are hoping to have a matched pair sample on this. The State, I understand, has had difficulty getting fresh data from the city in order that they can match people within the New York City environment, so we can have the most reliable kind of matched sample done.

Then we can go on to the whole aspect of the cost of having a baby. And then there is regionalization. Parenthetically, I want to say that a unit like ours is the ultimately sensible unit in a regionalization plan. We don't say shut the tertiary units, we don't say shut hospitals. We recognize the fact that they may be desperately needed by our mothers as well.

Mr. Scheuer. As backup.

Ms. Lubic. That is right. If every pregnant woman came through a unit like ours for screening, for example, she could shortly get to the appropriate level of care, and the baby need not be transferred.

I won't talk about the United States. I had a conversation with Sir John Stallworthy of Oxford about delivery of care and the problems that they had in Britain. They had to set up a flying squadron to go out to the home for home birth situations related to the reluctance on the part of an attendant, who would be in most cases a general practitioner, to seek specialist aid because (1) he needed the money or (2) he didn't want to admit that he didn't know how to manage this kind of case.

Now I don't know if that is applicable to the practice of obstetrics and general practice in the United States. I am not going to pass judgment on that. I am simply acquainting you with what I was told, and this was in the days, of course, before England had its national health service.

I think that one of the interesting things about what we are trying to do is to see if this can be done economically. We have been confronted over and over with the question: why didn't you do it in the hospital? And I should point out that there was no objection to our plan until in fact we had permission. This went through the Health and Hospital Planning Council in southern New York, the Comprehensive Health Planning Agency of New York City and the State Hospital Review. It was after we got permission that all the trouble started.

If you look at this country as having 3 million births per year, and even if you said, as did Dr. Vande Wiele, that 10 percent may be high risk—and even that may be a high figure—but let's say that only three-quarters of the mothers can be delivered in an institution like ours where the current fee is $750. That would cost $1,687,500,000 a year. If those 75 percent go to a tertiary unit—that is, a hospital with figures comparable to one that is located very near us—the fees for a perfectly normal childbearing experience would come to about $2,250—actually a little more than that, with $1,500 for the labor and delivery and 5-day hospital stay, $700 for the obstetrician and $30 for each prenatal and each postpartum examination. That comes to $2,330. This is the total fee in one tertiary unit.

Mr. Scheuer. Dr. Mayer will be asked to testify as soon as you are finished.

Ms. Lubic. If 75 percent of the mothers in the country delivered at a unit like that, the cost to the country would be $5,062,500,000. One of our concerns is that if all care is covered by a bill like this, there will be a corresponding move toward greater and greater use of technology because it is going to be paid for, it is going to be covered by a national health insurance program.

What we are trying to do is keep a unit operating as though childbirth is a normal physiological experience. We are keeping those supports we feel are necessary in an emergency situation, keeping a good backup and fitting it into a total program of obstetrical care which we recognize is a very important facet of care for mothers and babies in this country. All we want to do is test this concept.

Mr. Scheuer. Thank you very, very much.

Ms. Lubic. By the way, I would be happy to share with you our results, because we are coming now to the end of our first year of service.

Mr. Scheuer. Thank you very much for your very stimulative testimony.

Now, Dr. Shirley Mayer, will you find it convenient to testify now?

STATEMENT OF SHIRLEY MAYER, M.D., DEPUTY COMMISSIONER OF PROFESSIONAL STANDARDS REVIEW, NEW YORK CITY DEPARTMENT OF HEALTH

Dr. Mayer. Yes.

Mr. Scheuer. You can give us your testimony on the entire bill which we would very much like as well as any remarks that you would like to make in reference to the testimony that you have just heard. We would ask you to address us on the general aspects of the bill as well as the specifics.

Dr. Mayer. May I react first to the testimony you just heard from Mrs. Lubic?

Mr. Scheuer. And also the testimony you just heard—were you here when Mrs. Seaman testified?

Dr. Mayer. A portion of it.

Mr. Scheuer. I think they are both addressing themselves to the same general problem; namely, that women are thrust willy-nilly into a tertiary hospital bed setting for a normal birth when they might well have preferred a different modality like the home or the neighborhood clinic. We will enjoy hearing your reactions to really the central issue that they both addressed themselves to.

Dr. Mayer. I believe Mrs. Lubic made a statement in which I can concur, that their effort is to demonstrate whether deliveries in an out-of-hospital situation by a qualified staff can be done safely and economically and satisfactorily. I agree that this is heretic. I think the burden is upon them to demonstrate that it can be done safely, and until then it is considered an experimental form in terms of acceptable practice of obstetrics in this city and therefore the city health department has gone on record with the State as feeling this is in conflict with the qualifications for medicaid providers.

Dr. Bellin has said we will not assign a medicaid provider number to the maternity center and has suggested further that since we seem to be at an impasse that this be referred to the State attorney general's office. I am sure Dr. Bellin will be glad to share with you any data and the background correspondence relating to the Maternity Center Association.

Mr. Cutler. Other than folklore, what evidence do we have as to the safety and quality of the health care being provided in the hospital setting?

Dr. Mayer. Other than folklore? I don't know that that is folklore.

Mr. Cutler. What proof do we have with respect to the hospital?

Dr. Mayer. Well, I do think that we have certainly the improved figures of infant mortality and perinatal mortality over the years, that we have had supervised delivery in an in-hospital situation. I must say that I am not——

Mr. Scheuer. How do those figures compare with the delivery of the well children from healthy mothers in a home setting where adequate obstetrical care is available?

Dr. Mayer. I have not recently looked at a comparison of that nature. We do not have a large enough denominator of deliveries in a home situation for the comparison.

Mr. Scheuer. Well, apparently there are tens of thousands available.

Dr. Mayer. The ones quoted from Kentucky were done some years ago and I would say that if the mortality rate at that time was favorable with the mortality rate nationally that the national rate has now improved and I would have to know whether these are comparable figures at all.

Mr. Scheuer. How about your own information here in New York City? How many home deliveries have you reported in the last few years?

Ms. Lubic. Our home delivery service closed in 1959 because again we were trying to meet a need of a population that was ignorant about hospitals but the figures that we had for those 28 years where we were dealing with mothers in central and east Harlem and had to transfer from where they were in whatever tenement into a hospital if we got into trouble, and there was a nurse midwife doing the care in the home with obstetrical backup. They were comparable. As I say, they are a matter of the literature, and I can give you the bibliography on that as well as the Frontier Nursing Service figures that were reported in the January American Journal of Obstetrics and Gynecology of 1976, so they are also available in the literature.

Mr. Scheuer. What about experience abroad? Have there been any studies in England or the Scandanavian countries or Australia or New Zealand or Canada?

Ms. Lubic. I hope Dr. Mayer will agree with me on this that we agree not to compare ourselves to overseas because it is not really comparable. I think the fact that we are in the position that we are in perinatal mortality and we have more technology than most of the countries that do better would militate in favor of our looking at what technology does in the sense of improving care.

There is also another whole school of thought relating to improvement in infant mortality which deals more with the social improvements that have come about over the past couple of centuries, particularly like sanitation and improvement in nutrition and so forth. There is a man named McQuen who particularly shows very interesting charts, for example, on TB in England. He has charts because they kept statistics beginning in 1800 and can show where the decline in the incidents of TB came down like this and at the point when streptomycin was initiated. His whole point is that the health of a group of people relates as much to those social factors which was another point I was going to make with you about the nutritional supports in this bill.

So I think it is very difficult. While the infant mortality rates have dropped, and that is true, it would be a hasty judgment I think to say that this is all due to births going into hospitals when there have been all these other social factors.

Mr. SCHEUER. Let's get back to Dr. Mayer.

Dr. MAYER. I was not prepared to discuss New York's position on the maternity center.

Mr. SCHEUER. If you like, we would be happy to hold the record open if you want to submit any further statement on this.

Dr. MAYER. There is only one further item from Mrs. Lubic's statements that I wanted to react to and that was her estimate of the costs of delivering an infant in a hospital in New York City. I believe she quoted the figure of $2,200 for all costs which would cover prenatal. This is an extremely high estimate and it is not what we generally consider to be the cost of having a baby. I can quote a recent report on this subject written by Dr. Andrew Fleck of the State Health Department which I believe refutes those figures, citing the average cost of delivering a baby in hospitals as $750. This is for more than 1 day of care.

You have quoted $750 as the cost of care at the maternity center which I assume covers prenatal and one day of residence at the maternity center because the patient is discharged within the first 24 hours. I think these costs are certainly comparable, and therefore at the moment with the low volume at the center, there is no justification for saying that the maternity center is more cost-efficient.

Mr. SCHEUER. I really don't want to get into a lot of controversy about this. Let Dr. Mayer finish her testimony.

Dr. MAYER. Thank you.

The New York City Department of Health welcomes the opportunity to comment on the Scheuer bill and commends the philosophy and approach of this bill and its companion bill in the Senate proposing a national health insurance program for all children under 18 years and pregnant women.

The clear advantage of this approach to universal coverage, compared with other health insurance proposals that have come before the Congress, is threefold:

First, it initiates coverage at that end of the age spectrum where the least costly health services—namely, preventive services—do most to promote healthier and more productive lives.

Second, it allows the sequential phasein of successively older age groups with timing geared to the capability of expanding the tax levy.

Third, it leaves currently in place for those 18 years and older and nonpregnant the benefits existing under medicaid, maternal and child health and family planning (titles V and X) and ultimately medicare.

In the short time allotted me, I would like to discuss a few specifics from the bill—I will limit myself to very few—and then consider its implications to the city of New York.

Section 302 provides that the Secretary may delegate authority for administration of the system of payments to the Social Security Administration. It is very logical that the social security number should be the identifying number for all services and payments and that this will be detailed in regulations implementing the legislation. It would be preferable that application for a social security number not be left to the option of the parent or individual, as is now the case, but that it be generated automatically with the filing of a birth report. Also, all minors and women who are currenly in medicaid families should be automatically issued an individual social security number if they do not have one. This would greatly aid in serving adolescents, many of whom do not now participate in medical services because of their fear of loss of confidentiality, if they must use the family medicaid number. The social security number as the enrollment number seems to me of prime importance.

Section 203 deals with quality controls. The board is empowered to delegate to a State health agency or other appropriate State agency the determination of whether an institution qualifies as a provider. The bulk of preventive services to children is ambulatory, often provided outside institutions. Neither the State health agency certification nor a professional standards and review organization (PSRO) review is focused on ambulatory care settings.

Therefore, the implementation of PSRO functions, particularly coordination with and the utilization of existing title V standards, regulations and surveillance methods developed at State levels, will have to make haste much less slowly than to date to ensure quality controls. A requirement in this bill for coordination with title V regulations and standards would strengthen the quality assurance aspects. The title V payments for services are to be deleted; however standards developed under title V authority for performance of health services to specific groups should not be deleted or lost in the implementation of a more universal program for payments.

Mr. SCHEUER. Excuse me. It is a little after 1:30 now. If you have—

Dr. MAYER. Ten minutes?

Mr. SCHEUER. I think if you are going to go that long we probably ought to break for lunch and come back in about 45 minutes.

Dr. MAYER. All right.

Mr. SCHEUER. We will now recess and we will come back—it is 25 after 1. We will recess until 2:15.

[Whereupon, at 1:25 p.m., the hearing recessed, to reconvene at 2:15 p.m.]

AFTER RECESS

[The subcommittee reconvened at 2:30 p.m., Hon. James H. Scheuer presiding.]

Mr. SCHEUER. The subcommittee will come to order.

We will continue with the testimony of Dr. Shirley Mayer.

Dr. MAYER. Thank you, Congressman Scheuer.

I would like to continue just briefly. I had considered two issues in the bill—one, the utilization of the social security number. I recommended that it not be the option of the parent to obtain one, but that it be issued automatically with a birth certificate. Second, dealing with quality controls. I made the recommendation that a requirement in this bill for coordination of title V regulations and standards would strengthen the quality assurance. I had just come to benefits and would like to go on.

The scope of benefits provided is very comprehensive and general in wording. The advantage of permissive rather than detailed wording in the legislation is acknowledged. However, I find the failure to specify two cornerstones of preventive medicine in maternal and child health, that is, nutrition and family planning, of great concern. While it is true that these may be subsumed under "comprehensive services" and spelled out in regulations, unless appearing in the legislation, there is no guarantee that they will be so delineated.

With regard to family planning, although it would of course be covered during the 12 week postpartum period, there should be a requirement to arrange for continuing family planning services to women beyond the 12 week cut-off of covered benefits, as through referral to other low cost family planning clinics or neighborhood health centers with State or Federal funding.

The exclusion of drugs for outpatient services unless prescribed for longer than 4 weeks (10 days in the Senate version) seems in either case an undue restriction for patients in the lowest economic brackets. Since most acute childhood illnesses are treated on an ambulatory basis and require treatment for less than the 10 day/4 week minimum, there must be some mechanism (at public expense) to cover the required drugs for children of poverty families; otherwise, acute illnesses will end up in hospitals at more costly care.

Whether accomplished through State or local welfare agencies, or as we might do in New York City through purchase of drugs by the Health Department for its direct clinical services, all these would necessitate financial screening and duplicative administrative costs. It might be less cumbersome to include drugs in the covered support services for special population groups, under sections 232 and 233.

Section 503, Conforming Amendments. Synchronization of phasein of new maternal and child health benefits to coincide with deletion in whole or in part of other legislative authorities for funding of maternal and child health services must be carefully addressd by the Congress. Maintenance of presently organized and newly developing comprehensive health services for mothers and children, as the older crippled childrens program and the programs of projects now under State agencies (MIC, C&Y, Intensive Care Units) is essential to provide the services to a greatly enlarged population base. Money for reimbursing for services provided by this bill must be not only already in the pipeline but all the mechanics must be in place and operating to continue services to patients now using these projects by keeping funds flowing to the providers.

I would like to turn now to a consideration of some implications for New York City if this bill is enacted.

A few baseline statistics are necessary to appreciate the fiscal burden now carried directly by the city or in combination with the State to provide necessary medical services to its mothers and children.

Number of children under 18 years (1970 census)	2,200,000
Number of children under 18 years living in poverty areas (1970)	1,100,000
Number of children medicaid eligible (1976)	700,000
Number of resident live births (1975)	102,000

The percent of those live births in medicaid-eligible families for the first 8 months of this year, 1976, is 37.5 percent.

Mr. Scheuer. More than one third of all live births are in the medicaid category in New York City?

Dr. Mayer. Yes; this means an overrepresentation of the medicaid population among total births.

Expenditures: City tax levy funds for direct operation of clinical services for children totaled $12.5 million in fiscal year 1976, distributed among Child Health Stations, including the pediatric treatment centers, day care and school health, dental health and services of the Bureau for Handicapped Children. The State contributed an additional equal amount for these services in New York City.

City funds comprising the 25-percent required local match for medicaid services to children and pregnant women were calculated for 1975 as follows:

	Millions
Medicaid for 700,000 Children under 18 years:	
Based on $275 as average total medical cost (inpatient and outpatient) equals $192,000,000 ($96,000,000 Federal, $48,000,000 State and $48,000,000 municipal)	$48.0
Medicaid for maternity costs:	
Based on $1,000 per patient for 37,000 patients ($750 inpatient, $250 out-patient; average 6 visits at $40)	9.5

102,000 live births by 37.5 percent equals 37,000 patients, $66,000,000 total, $33,000,000 Federal, $16,500,000 State, $16,500,000 municipal.

To this must be added a proportion of the city's $300 million support to the Health and Hospitals Corp. for services to those above medicaid eligibility, not fully covered by other third party, and able to pay only partial out-of-pocket costs. The estimated figure is $60 million. You will recall that from the statistics of children under 18 there were some 2.2 million and there were 1.1 million who lived in poverty areas but only 700,000 of those living in poverty areas were medicaid eligible, leaving a balance of 400,000 to be paid for by the city or partial payment.

Computation:	*Millions*
400,000 medicaid-ineligible children at $275 per patient and assuming 50 percent collection	$55
Plus 20,000 medicaid-ineligible deliveries at $1,000 per patient, and assuming 75 percent collection	5
Total	60

That totals $60 million for the medicaid costs, $60 million for the costs above medicaid for persons unable to pay out-of-pocket costs or who do not have sufficient insurance coverage.

Addition of the amounts in these categories totals $197 million—roughly $200 million—contributed by the city annually. The services purchased, even at this cost, must be recognized as minimal and often discontinuous despite the best efforts of all involved. Thus for New York City dollars alone would dictate favorable consideration of the Scheuer/Javits bills. Beyond the fiscal advantage, its enactment would do much to alleviate problems inherent in medicaid for this age group, problems which continue to frustrate those concerned for example with the EPSDT requirement of title XIX. It should markedly reduce the administrative costs of eligibility determination and recertification, overcome the discontinuity of services to children consequent upon losses of eligibility, and through the institution of a unique registration number, the social security number, permit the necessary follow-up on referrals, diagnosis, and treatment through tracking of all services provided to one individual. At present this is frustrated by the fact that children are served in medicaid as members of the medicaid family and don't have individual numbers.

This bill thus has the endorsement of the health department for the reasonably anticipated benefits to be derived for the health of the city's mothers and children.

Thank you.

Mr. SCHEUER. Thank you very much.

We will hear from Larry Morgan, who represents district council 37.

STATEMENT OF LARRY MORGAN, HEALTH PLANNER, DISTRICT COUNCIL 37, AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES

Mr. MORGAN. Thank you.

My name is Larry Morgan. I am a health planner with District Council 37, American Federation of State, County and Municipal Employees. I am here speaking on behalf of Victor Gotbaum the executive director of the Council. My remarks will be very brief.

We have had time to review the highlights of the proposed bill. Including spouses and employees, the council represents 85,000 women in New York alone of which 50 percent are of childbearing age. In addition, we cover well over 100,000 children.

Over the past year and a half the health and security plan of the District Council 37 has done in-depth studies of the hospitalization experience of members. We found the general level of care to be mediocre at best and generally appalling. Preparation for childbirth, according to the women of our union, is considered to be very inadequate. We found insurance for maternity to be nominal. We found the structure of the medical insurance system is such that preventive services are inhibited. Children don't receive care when they are healthy, they wait until they are sick.

District Council 37 wishes to applaud both the intent and the content of the Maternal and Child Health Care Act. We feel we need a strong approach to the quality of and access to health care for the mothers and children in this country. It is both comprehensive and potentially cost efficient. It addresses the problems at a basic health level where we believe they can be solved.

The lessons in national health insurance in this Nation are grim. Half a century of attempts to have a single national program have been thwarted by vested interests. The alternative paths of insuring selected populations was chosen in the midsixties with medicare and medicaid and the present bill is an extension of that same philosophy. Whether this encourages the single national health insurance program is not clear.

If this bill is implemented with the same lack of cost control and the same potential for the same abuse of medicare and medicaid, the outlook is not promising. From our review of the bill we do not believe this to be the case. This is a bill that attempts to provide better health care for mothers and children, not more money for doctors.

I might add that the special provisions for capitation payments are particularly encouraging. Briefly, we see several areas where this bill may be strengthened. For example, we would like to encourage greater utilization of paraprofessionals where possible, particularly in the maternity area, and I refer to midwives.

Mr. Scheuer. I might say here that I was the congressional sponsor of the new careers program which has turned out to be a major element in the concentrated emergency employment program. I have a deep commitment to creating ladders from the nonfunctional or disfunctional portion of our society into careers in public service leading to professional credentials and professional qualifications. It is my absolute conviction that there is a great deal of talent and a great deal of understanding and knowledge out there in the neighborhoods that we are able to tap on. Our public services would be enormously enriched, when we learn how to tap all the caring and the concern and the knowledge that is out there. I am sure that the bill in its final form will reflect your concerns.

Mr. Morgan. I agree with you very much. One of the problems is that some of them end up on ledges and if you get on the wrong ladder at the wrong time you never move to another ladder.

One further point——

Mr. Cutler. I wanted to point out for both Senator Javits and Mr. Shaffer the bill in fact does reimburse to other than the physician which is an almost historic first in any form of national health legislation.

Mr. Scheuer. In other words, the nurse extender, the physician extender are compensated directly so that they work under the supervision of a professional but they are paid as independent contractors; is that correct?

Mr. Cutler. Yes.

Mr. Morgan. Another issue we would like to encourage you to extend is the second surgical opinion service to beyond the tonsillectomies and adenoidectomies for children. Those are, as you are aware, operations that are abused frequently. They are also low cost operations as compared to some of the real abuse that goes on in surgery as we found out in New York City because we have been running a second surgical program for a number of years.

Mr. Scheuer. Which other operations for children?

Mr. Morgan. I don't have a particular number of surgeries in mind for children. As far as mothers, I would like to see if there is a possible way of extending this bill to cover some of the real abuses that are performed on women's bodies in New York.

Mr. Scheuer. Hysterectomies?

Mr. Morgan. Yes. We run a second surgical consultation program and we found 43 percent of hysterectomies recommended by the initial physician to be unnecessary.

Mr. Scheuer. Are you familiar with Willie Sutton's law? Willie Sutton had a much higher skill.

Mr. Morgan. A pool player?

Mr. Scheuer. No, he was a bank robber. He was asked, "Why do you rob banks?" and he said, "That is where the money is." We followed Sutton's law in picking out tonsillectomies and adenoids operations. The preponderance of funding for operations on children is in those two operations. We did that for starters but I don't suppose there is any authentic reason.

Mr. CUTLER. No. In fact, the bill has broadened the scope to any diagnostic or therapeutic procedure performed on a child without a second consultation when the board recommends that that occur. We have taken away the limitation for tonsillectomies.

Mr. MORGAN. I have only one final point I would like to make. As I had mentioned before, the way that health insurance programs are developing in covered specific populations they start with the elderly and the poor and have now moved toward women and children. I think it is almost a political necessity the way these bills are coming about this way but it brings with it the inherent problem of fragmentation. I would like to encourage that at the same level that you are proposing a maternal and child health board, that a broader scope panel be set up to coordinate benefits with medicaid and with medicare.

Mr. SCHEUER. We have heard that suggestion this morning specifically from Dr. David Pomrinse, the director of Mount Sinai Hospital, and it is a point that is extremely well taken. Sometimes the administrative apparatus gets beyond control and it must be rationalized. I think we all agree with your last point very strongly.

Mr. CUTLER. No further questions.

Mr. SCHEUER. Thank you very much, and thank Mr. Gotbaum for sending us this message.

We would now like to have the representation from the National Hemophilia Foundation. You can introduce yourselves seriatim for the record.

This is Mr. George J. Theobald, Jr., executive director of the National Hemophilia Foundation, and Dr. Louis M. Aledort who is the medical director.

Please proceed.

STATEMENT OF GEORGE J. THEOBALD, JR., EXECUTIVE DIRECTOR, NATIONAL HEMOPHILIA FOUNDATION, AND LOUIS M. ALEDORT, M.D., MEDICAL DIRECTOR

Mr. THEOBALD. We are delighted to have an opportunity to testify on the legislation because we think it is a great step forward for as proposed it almost fits the problems of hemophilia like a glove. I think you know hemophilia is a genetic disease. It has the misnomer, quite frankly, of a royal disease as those of you know who read Bob Massie's book on Nicholas and Alexandria.

We have testified before your committee before on other pieces of legislation. Now that the Government is funding the kidney dialysis programs, hemophilia is the most expensive chronic disease in the United States today and therefore we think that this legislation—we do have some comments to make upon it because Dr. Aledort and I have worked over the weekend—is a great step forward.

I want to turn to Dr. Aledort who will talk on the disease itself and present our specific suggestions as to how the bill should be changed to implement proper care. We have already submitted to you our written testimony.

Mr. SCHEUER. Your testimony will be printed in its entirety in the record [see p. 252].

STATEMENT OF LOUIS M. ALEDORT, M.D.

Dr. ALEDORT. Congressman Scheuer, I am Louis M. Aledort, department of medicine at the Mount Sinai School of Medicine and director of the International Hemophilia Training Center at the hospital and medical director of the Hemophilia Foundation.

It is very pleasant to see a lot of familiar faces up there, some of whom we have talked with before.

I am particularly pleased to speak briefly about this bill. As Mr. Theobald stated, we have entered an official statement for the record. This bill, Maternal and Child Health Care Act, specifically addresses most of the problems that people with hemophilia have and it is particularly a happy one for those who practice medicine in the State of New York where we have dragged far beyond others in recognizing the unique problems of hemophilia through State legislation.

Briefly, hemophilia, being a genetic disease, means that it is carried directly frequently unbeknownst to the mother through the X chromosome and it is therefore of importance that we have an ability to recognize the carrier state for family counseling. People born with hemophilia have it forever and they are missing a simple protein, a clotting factor. Without this protein, bleeding will occur spontaneously into joints, into vital organs and they may very well die from the disease. However, we have through modern technology been able to support and essentially "cure" patients with hemophilia because we have been able to extract from human blood that which they are missing. Of the approximately 25,000 cases in this country who are severe enough to need chronic therapy, this technology has made possible treatment with this blood factor.

Of interest, the median age of the group is 11.5 with 80 percent of the cases under 18. The therapeutic modality for this disease in addition to the blood resource, has been a comprehensive care. This is certainly not unique, but works very well as a multidisciplined team approaches the many facets of the problem particularly using the community resources.

The essence of the disease, however, is still the replacement material which is the missing factor derived from human blood. The cost of care is related to the diagnostic, the medical, and use of paramedical personnel. In addition success depends on social service personnel as well, and rehabilitation and vocational counseling.

The major cost of the material itself, throughout the United States, is approximately $3,500 a year. This does not include any medical care or hospitalization. A very important new aspect of therapy is home care or self-infusion similar to the ability to give oneself insulin at home or to dialize people at home. One can now self-infuse or the parent can infuse the patient. We see large numbers of people going to work and to school and they just leave the room to give themselves a transfusion.

The use of this treatment has markedly decreased the total cost of care and these people, children particularly, are not losing time from school. The major problems we face are the small percent receiving comprehensive care, the few who have resources to pay for it and the inadequate third party payment program particularly for outpatient and home care.

As I stated before, this bill addresses the problems in many, many ways and is most welcome. We are however concerned about six particular points. One is that blood and blood products in America, according to the FDA, are now considered drugs. Since it is the key factor in the treating of hemophilia (or sickle cell disease), it is particularly our concern that it is clearly stated in this bill that blood and blood products, derivatives of blood—either red plasma cells or plasma fractions—be covered, in addition to the hospitalization costs.

In addition to the broad coverage it is important that it be clearly stated that it was also covered as outpatients hospital coverage as well as at home. In addition, if it is called a drug, in the bill it is stated that you must have the drug longer than 10 therapeutic days. It is not clear whether we are talking about 10 therapeutic days in a row as one would take penicillin or as blood and blood products are frequently given, episodic, and thus, more than 10 within a given year, but not in a row.

The second aspect is the dental care. Now, in general, most people with other diseases rarely have dental problems prior to the age of 4 and therefore the statement that 4 is a good age to start compensation is probably very good. However, the hemophilia has a significant fear of bleeding from brushing which leads to early dental problems that are quite expensive. It is likely that extractions are followed with a significant amount of bleeding and hospitalization. Many of the dental programs that have evolved foster prophylaxis so that patients will not have dental difficulties. This is still not the case throughout the country. Thus I think it might be important to look at the dental aspects which affect the teeth very early.

In terms of home care services, I think it is important that we recognize that in hemophilia, physical therapy, home care monitoring by public health nurses takes place in the home setting and should be included as home health care services which are reimbursed.

The fourth aspect is the diagnostic services. Now the mother has diagnostic services required in the prenatal area particularly in trying to determine whether or not she is a carrier and this is not covered at all in the bill in terms of prenatal laboratory services. The child, of course, has a frequent use of the coagulation laboratory, but I think it is important to recognize that in the bill you state that the labs be pathology labs. In the Southeastern part of the United States, these labs are frequently under the aegis of pathology. In the Northeast and the West they are under the aegis of medicine and a hemophiliac would have difficulty being reimbursed if the language remains "pathology laboratory."

I don't know the exact page but it says that the laboratory should be a pathology lab, Sections 202, 223 and 301. Now this could cause a great deal of confusion particularly if it is going to be a complicated billing operation, so I think it might be important to clarify that.

The last point is that psychiatric services, which was in the formal setting—and I am really not sure what you meant by that but certainly patients, young children, who have need of psychiatric services such as hemophiliacs because of frequent painful bleeding with significant morbidity are not always in a rigid confined setting but are in groups in the home, in clinics, et cetera. So I don't know whether one needs to clarify that but it does say in a formal setting for reimbursement. I am not sure exactly I know what you meant.

Those are my comments as it relates to the bill. Once again we are delighted to have a bill like this introduced. It really meets head on the needs of these hemophiliacs in our State and in the country and would be most welcome.

Thank you.

[Mr. Theobald's and Dr. Aledort's prepared statement follows:]

STATEMENT OF GEORGE J. THEOBALD, JR., EXECUTIVE DIRECTOR, NATIONAL HEMOPHILIA FOUNDATION,[1] AND LOUIS M. ALEDORT, M.D., MEDICAL DIRECTOR

We are profoundly grateful for the proposals you have made under the legislative title "The Maternal and Child Health Care Act", a national health insurance system for maternal and child health care. We know that you and your staff have worked for a very long time on this bill, in order to have it fit into the present health legislation structure, and that many days more of work will be necessary to get this legislation passed.

We would like to pledge whatever efforts you will require of us to help get this legislation enacted into law.

Frankly, this legislation, with the exception of a few minor expansions, fits the problems of hemophiliacs like a glove.

However, before I comment on the legislation, I would like to explain some things about hemophiliacs.

HEMOPHILIA AND ITS TREATMENT

There are, according to the National Heart, Lung, and Blood Institute, approximately 26,000 hemophiliacs in this country who are severely or moderately severely affected with this disorder. We estimate that the total number of hemophiliacs, including those classified as "mild", may be 100,000.

Hemophilia is a genetic disorder of the blood in which a clotting factor is either partially or completely missing. Hemophiliacs are unique among chronic disease victims because they are not born crippled and can be helped to live a normal life if they receive proper care and if financial conditions allow them to obtain the missing clotting factor. Without this ongoing treatment, the hemophiliac becomes an unnecessary burden to himself, his family, and to society.

The sufferer is subject to spontaneous hemorrhaging both internally and externally. With the repetition of internal bleeding episodes, the hemophiliac literally becomes crippled by his own blood. A bleeding episode may occur without warning. Consequently, there is a tendency among family members to curb day-to-day activities for the sake of the sufferer. The psychological toll is incalculable, and in some ways, devastating. Even with optimal genetic counseling, hemophilia has an extraordinary high rate of occurrence with 30% of all new cases occurring in families with no known history of the disease. Therefore, hemophilia has the highest rate of mutation of any genetic disease.

Medical advancements provide us with materials capable of correcting the disorder by replacing the missing clotting factor. Bleeding can usually be checked with transfusions of fresh whole blood, plasma, cryoprecipitate or clotting concentrates. This procedure is known as replacement therapy; 26,000 patients are severely enough involved to require continuous replacement therapy from birth to death.

The hemophiliac poses specific medical and financial problems:

(1) Replacement material is extremely costly, the average expenditure running from $5 to $30 a unit, or about $2,000–$5,000 per patient per year.

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[1] The National Hemophilia Foundation, located at 25 West 39th Street, New York, N.Y. 10018, is a voluntary, nonprofit health agency, and the only national organization concerned with the disease of hemophilia. The Foundation is an active member of the National Health Council, and furnishes reports to the National Information Bureau. It maintains an active liaison with the American National Red Cross and other organizations that are concerned with assuring an adequate, safe, and reasonably priced supply of blood and blood products to those who require it. The Foundation is also a member of the American Blood Commission. For further information, contact Mr. George Theobald, Executive Director.

(2) Replacement therapy is generally carried out in an outpatient emergency room where "third party" coverage is often unavailable.

(3) Reconstructive surgery for correcting crippled joints is both time-consuming and extraordinarily expensive, and the cost of blood products alone, without doctors' fees or hospital costs, can be as much as $15,000. Again, this is rarely covered by "third party" payments.

(4) In the past ten years, there has been a marked increase in blood product utilization by hemophiliacs, and the National Hemophilia Foundation is continuing and furthering its efforts in blood donor recruitment. Recognizing that the increase in blood use could outdistance the supply, we have advocated the concept of "component therapy". This means that a unit of blood is broken down into its basic components (e.g., red cells, serum albumin, etc.) and then these can be distributed according to specific needs. The hemophiliac, for example, needs only a small plasma portion called cryoprecipitate; a leukemic is unable to use the platelets derived from the same unit; while another patient, perhaps hospitalized with a bleeding ulcer, might use the red blood cells. One unit of blood, then, can meet the blood needs of many patients.

HOME THERAPY

A hemophiliac can live a useful life as long as replacement therapy is readily available. When it is, hemophiliacs—whether they are students or employed—show a positive attendance record. But the time spent waiting in hospital emergency rooms is compromising and costly. It is for these reasons that many areas of the country have successfully initiated programs of "home therapy". At the onset of bleeding, a patient may give himself an infusion of the necessary blood component which will control both pain and bleeding. This is being carried out at home, at work, and at school. There is no question that "home therapy" provides the most satisfactory treatment for the hemophiliac, particularly if we believe that the aim of modern medical care is to decrease the need for hospitalization and government-dependent patients. It is vital therefore, that in addition to in-patient coverage, both out-patient and home care programs be covered in national legislation.

Essentially, we face two problems: One is the rehabilitation of patients already crippled; the second is the long-range management of the newly diagnosed child. Both problems create extensive financial drains on families and communities, setting aside for the moment the emotional strain and social stigma.

The costs of out-patient replacement therapy are still beyond the normal financial capacity of the average family, and many families become medically indigent as a result. This is why coverage of replacement product costs is so desperately needed by hemophiliacs. It is important to realize that even though the initial cost of providing such coverage for out-patient replacement therapy may increase the public burden for the moment, the long-range expense to the taxpayer will be lessened as more and more hemophiliacs are able to maintain their health, become educated, work without great absenteeism, and eliminate the need for public assistance.

Again, I would emphasize that hemophiliacs can become functioning, productive members of our society if they are able to obtain adequate therapy. By a continuous replacement of the missing clotting factor, they are able to become the living dividends of the very investment your legislation provides.

THE LEGISLATION

It is our understanding of the bill that it would provide:

1. *Comprehensive ambulatory and hospital care for children from birth up to the age of 18. Preventive health services are included in the benefit package.*—A recent National Heart, Lung and Blood Institute study indicates that 81.8% of the hemophiliacs in the U.S. are under the age of 18.

The median age is 11.5, half that of the general United States population. Older hemophiliacs may be under represented because (1) they were raised in the era when treatment was limited and do not now seek it out, (2) younger people more routinely seek medical help, (3) more young hemophiliacs are surviving now increasing the number of young hemophiliacs in relation to the few surviving older ones.

Below is a table which shows the age distribution:

AGE DISTRIBUTION OF HEMOPHILIACS AND MALE POPULATION OF THE UNITED STATES

Age group	U.S. male population, 1970		Hemophiliacs in United States	
	Percent	Cumulative percent	Percent	Cumulative percent
Under 3 yr	5.2	5.2	8.9	8.9
3 to 4 yr	3.6	8.8	15.3	24.2
5 to 9	10.3	19.1	19.8	44.0
10 to 14	10.7	29.8	25.1	69.1
15 to 19	9.7	39.5	12.7	81.8
20 to 24	8.0	47.5	6.5	88.3
25 to 34	12.4	59.9	7.3	95.6
35 to 44	11.4	71.3	2.1	97.9
45 to 54	11.3	82.6	1.4	99.1
55 to 59	4.8	87.4	.3	99.4
60 to 64	4.1	91.5	.3	99.8
65 to 74	5.5	97.0	.2	99.9
75 or older	3.0	100.0	.1	100.0
Total	100.0		100.0	
Median age (years)	26.8		11.5	

Currently, as we indicated, the cost of blood products, per year on the average, is about $2,300. The NHLBI calculates the average costs for other medical expenditures is over $1,000 (these are both 1971 figures—approximately a 50% increase should be added for the costs of inflation). Over 25% of families pay more than $2,000 per year. Below is a chart which shows the expenditures.

TOTAL CASH EXPENDITURES FOR BLOOD PRODUCTS AND OTHER CARE AMONG FAMILIES REPORTING EXPENDITURES

	Number	Percent
Less than $500	92	44.9
$500 to $999	31	15.1
$1,000 to $1,999	34	16.6
$2,000 to $4,999	24	[illegible]
$5,000 to $9,999	17	[illegible]
$10,000 and over	7	3.4
Total	205	100.0

Obviously, this constitutes a severe drain upon family finances, and contributes to family stress. To help meet family expenses, over one-fifth of the patients' fathers moonlighted working a second or part-time job. One-third of the mothers who were employed stated that their sons' disease was a major reason for choosing to work.

According to an NHLBI survey, forty percent of persons interviewed felt that their current family income was inadequate for the future marginal now, or a major immediate problem. A number of families were indebted to the local hemophilia foundation for plasma which had not been replaced or paid for—sometimes this indebtedness amounted to thousands of dollars. Pre-adolescent and adolescent hemophiliacs often felt guilty about the financial strain they placed on their families.

In regard to the age 18 limitation, while we are deeply grateful for this proposal, you should know that we will continue to press for legislative assistance beyond that time frame.

Hemophiliacs, due to changes in care, are in fact living longer, and are becoming more fully productive members of society.

However, even presently, when young hemophiliacs reach adulthood, their care is often disrupted. In some cases, they are no longer eligible for care under a state's crippled children's program and now they cannot find adequate medical insurance coverage. Or, the center they attended offered only pediatric care; they now must seek care elsewhere.

Insurance opportunities are limited. For example, in a two-state study by the NHLBI, more than fifty percent of hemophiliac families reported they had been denied health insurance at least once.

Even if health insurance is acquired, many insurance policies set limits, usually about $10,000 or $20,000, on the amount they will pay on any one policy. This limit is insufficient for hemophilia and restricts care. Insurance policies may be cancelled because of heavy usage. Generally, Blue Cross very deliberately excludes coverage for blood products in an attempt to foster an all volunteer blood donor system.

Also, in most cases, employee disability insurance and workmen's compensation are denied to hemophiliacs because actuarial risks are too high. Hemophiliacs have been routinely denied life insurance.

Additionally, where insurance does not exist, difficulties arise. Payment seems to affect the course of the disease. Those patients having limited medical coverage are more likely to treat conservatively or undertreat their hemorrhages than are adequately insured patients.

It has been suggested that hemophiliacs who are in debt to blood banks or hospitals tend to resent their financial indebtedness and may present a hostile facade to treatment centers. Physicians, in turn, may resent the patient for not acting deserving while enormous blood bills mount up. In such a situation, the care the hemophiliac receives may suffer and the hemophiliac may neglect his disease.

Rehabilitative efforts also may fail. There is little incentive to undertake extensive retraining if it means having to pay a larger percent of the cost of care from a still limited income.

A word should be said about comprehensive care for the hemophiliac. The following are those components of care we would see as necessary:

Initial identification of hemophilia, typically by family and personal physician, and referral to center;

Laboratory work-up and diagnosis, including: coagulation, hematology, immunology;

Complete medical history and physical examination;

Orthopedic evaluation, including: X-ray, range of motion studies;

Dental evaluation, including X-rays;

Psychological and/or behavioral evaluation;

Entrance into treatment program and definition of treatment program;

Counseling sessions with patient and family regarding: nature of the disease, orientation to available financing and social service programs, training to recognize early hemorrhage, and training in disease management;

If patient is to be placed on a self-infusion (home care) program, training in self-infusion;

Outpatient clinics for follow up care; usually regularly scheduled clinics for orthopedic evaluation and care; dental care, physical therapy;

Complete preventive (prophylactic) care;

Program for procurement of blood products.

2. *Dental services for children age four and over.*—This gives us cause for concern. Dental problems can be severe for hemophiliacs, and dental problems are in fact medical problems, because of the attendant problems of bleeding. We presume that related medical care would be paid for even in children under the age of four who must have dental care. (Section 211.)

3. *Rehabilitative, social, mental health, nursing home and home health services will be provided when certified by a physician as necessary for the health and welfare of a child.*—In regard to this section, which appears in Section 216 in the bill H.R. 14497, we note that psychiatric and psychological visits are limited to sixty visits annually, and also note that in Section 211, mental health services are to be provided only in an organized setting. We are concerned that in some cases this will not be possible for the severe hemophiliac and believe there should be some provision made for exceptional cases.

4. *Drugs and biologicals prescribed for a child for a period of longer than four weeks are covered (Section 217).*—Blood and blood products used in the care of hemophiliacs probably would be covered, but we would like to have that portion of the bill and in the bill report state that for the purposes of this legislation, blood and blood products utilized in the care of the hemophiliacs, be considered as prescription drugs.

5. We would prefer to have the sections (Sec. 202, 223, 301) where in a "qualified pathology laboratory" is specified, also include the blood coagulation laboratories which are usually part of the Department of Medicine in many institutions. This is especially important for the diagnosis and treatment of all blood disorders and diseases.

6. While this legislation provides for a comprehensive coverage plan, it well may develop that a yearly deductible, so common in most major medical insurance plans, may be considered necessary. (This may well happen under Section

313.) If indeed this becomes a reality, we strongly urge that the hemophiliacs, and others with chronic diseases whose treatment costs can be described as "financially catastrophic", be required to satisfy this requirement on a "one time only" basis, rather than re-qualify each year.

The Foundation continues to be grateful for the concern of the Congress on the problems that hemophilia presents, and appreciates this opportunity to present the testimony.

Mr. Scheuer. Well, thank you very much. You have given us a great deal to think about.

Do you foresee any breakthrough in the future for treatment of hemophiliacs other than this very expensive mode of treatment that is being described?

Dr. Aledort. The only potential breakthrough is the ability to synthesize the missing clotting factor so that it could be taken orally or intravenously inexpensively. I must say that large sums of money are being spent from the National Institutes of Health, to solve this problem. It is still a very large protein that has not even been fingerprinted yet and it may never be able to be made synthetically. Because of that we are very much involved in a fallout from the blood banking of component therapy—and where the total unit of blood can be used for the hemophiliac for bleeding, the burn patient, and sickle cell can use the same unit of blood. I think it is a long way before we find an inexpensive modality unless we see a complete change in the cost accounting of blood banking in the United States which is another whole story which I will not go into.

Mr. Scheuer. In terms of blood banking, in many foreign countries blood is made available free; in this country it is very expensive.

Dr. Aledort. The countries in which blood is free are those that have national health insurance programs. Even in places in our own country where the donations of blood are all voluntary the cost of processing the blood is still extremely expensive. Just as an example, in one survey the cost of an international unit factor rate of which a child needs thousands and thousands of them at a given year it ranges anywhere from 3 cents to about 18 cents in different parts of the country according to where it is made and how it is packaged and how big the blood banking program is in that given community. The American Blood Commission is certainly dedicated to creating a national blood policy so we can come to grips with this problem but I think it is a long way in coming.

Mr. Carter. Do you have any figure on a cost for the full treatment of hemophilia?

Dr. Aledort. That is a very good question because part of the Health Services Administration Act that has gone into effect as of October 1 is to exactly address that so that one can begin to dissect out the total cost for a regional population. The only good figures come from a small group in Boston who have had a total care program where they are on home care which is approximately $5,000 or $6,000 a year. The problem with that is that they are only seen in the center once a year because they are very far away and they don't have a totally supported program so that we really can't come up with that figure. Hopefully at the end of this year we can say what it really costs.

Mr. Scheuer. Thank you very, very much.

Dr. Aledort. Thank you.

Mr. THEOBALD. Thank you.

Mr. SCHEUER. Now we will have the group from Cooley's Anemia Blood and Research Foundation for Children.

Give us your names for the record.

STATEMENTS OF ALFRED ADDESSI, VOLUNTEER, COOLEY'S ANEMIA BLOOD AND RESEARCH FOUNDATION FOR CHILDREN; DENA BENNETT, MEMBER, FICAIRA CULTABIANO CHAPTER, BROOKLYN, N.Y.; AND PAUL BIANCHI, NATIONAL LEGISLATIVE CHAIRMAN

Mr. ADDESSI. My name is Alfred Addessi and I am a volunteer of the Cooley's Anemia Blood and Research Foundation for Children. I hold the position of president in the Brooklyn chapter. I am the parent of four children and there is no incidence of Cooley's anemia in my family.

I have with me Miss Dena Bennett, who is a native of Carnarsie and who is chairperson of the young adults committee of the Brooklyn chapter, who will describe the functions of the Brooklyn chapter and also Mr. Paul Bianchi, of the Long Island chapter, who will describe the aspects of the bill that we are concerned with.

Before I deal with the nature of the disease I would like to take this opportunity to thank you, Mr. Scheuer, and members of this committee for your past support—and especially for sponsoring the Mother's and Children Act.

Cooley's anemia is an inherited blood disease also known as Mediterranean anemia, and medically called thalassemia, which is predominately found in children of Italian and Greek ancestry although, because of the widespread intermarriages, the disorder is also found in children of all ethnic backgrounds.

We have no definite statistics on this but I can quote Senator Edward Kennedy. He stated there were approximately 200,000. We believe the figure is much higher simply because where statistics were made in countries in Europe, as an example in Greece, they estimated there was about 25 percent of the population that had it.

Mr. SCHEUER. That 25 percent was affected?

Mr. ADDESSI. No; the carrying trait. This is not the disease itself but they have the possibilities of passing on the major disease. I believe it is really about 20 percent. So based on this we feel the figure is much higher because of the intermarrying and everything else.

In the disease there are two main types—Cooley's anemia trait and Cooley's anemia major. Persons born with the trait are not affected by the disease other than the fact that they carry a defective gene. When two people marry who are carriers there is a 25-percent chance that their offspring will be born with Cooley's anemia major.

The children born with the major have defective red blood cells which don't have the normal life expectancy of a normal cell. As a result, there is an insufficient supply of oxygen to the vital organs and this results in poor growth and development and eventual death in their teens after much pain and suffering.

At present there is no cure. The only treatment administered to these children right now are regular and periodic blood transfusions which vary according to the child. In their younger years they generally receive blood transfusions every 4, 5, 6 weeks, and as they grow older the frequency of blood transfusions becomes necessary more often, say every 2 weeks, as long as they live.

I am not a physician so I could not go into the medical aspects of it or the hemophilia problems. If there is any other additional information, I am sure we can have our medical adviser who was not able to attend today supply it. I understand some of this is reported in the official record.

So other than that, as blood is the bridge for their life, I would call on Miss Dena Bennett at this time to explain the functions of our chapter which includes information on our blood program.

Mr. SCHEURE. We are happy to welcome Miss Dena Bennett representing the fine community of Carnarsie.

STATEMENT OF DENA BENNETT

Miss BENNETT. I am Dena Bennett, member of the Ficaira Cultabiano Blood and Research Foundation for Children of Brooklyn. I am one of 600 members of the Brooklyn Chapter who help support, with contributions, the work of the foundation.

At the chapter level one of our functions is patient care. One of the things we have accomplished in this area is to build a hemophilia room at Long Island College. Before we provided for this room children were being transfused in wards and sometimes in the emergency rooms and even in hallways with kids running in and out and even sometimes knocking the needles out of their arms, and this created a terrible strain on the child. Transfusions at this time took from 12 to 24 hours with severe reactions.

Mr. SCHEUER. An individual transfusion?

Miss BENNETT. Yes; an individual transfusion. The child has received blood and kids would be running around. Of course they are lying there and the needle was in their arm and they are receiving the blood. A child can come down and move the cord from the arms and knock the needle out, and of course that would create another problem, either the vein busted and they would have to stop the bleeding and put the child through another condition to put the needle in another arm, and this would go on.

Mr. SCHEUER. And that process of transfusion could take up to 24 hours?

Miss BENNET. Well, see, we didn't have the conditions at that time, emergency rooms. Other people are running in and out. What happens is that after the child is transfused they run high fevers. Some of the children are up to 103, 104 and it takes time to come down where it is an alcohol treatment and the child is not allowed to leave the hospital until the temperature returns to normal.

Now having built the new hemotology room the child is home within 4 hours. We have a room with comfortable beds. We had set up chairs for the parents. We have given them a television set and they have a better atmosphere.

We have two blood drives a year which provides blood for the Brooklyn area for the children at no cost to the patient. In fact, no Cooley's Anemia patient has had to pay for blood in the past 15 years because of our work.

We also provide ambulance service for children unable to use conventional means of transportation. In other words, some of our children, their bone marrows become so soft they cannot walk so they have to be transported to the hospital in wheelchairs. We provide the ambulance service for that.

We have an annual dinner and dance and a number of other functions—a little exciting but all moneymakers. One of our ideas was to have T-shirts made up with the Cooley's Anemia emblem on it that we sell at all our functions which is how we help in our fight for life. I would like to present this T-shirt to you, Congressman Scheuer.

Mr. SCHEUER. Thank you very much.

Mr. Bianchi.

STATEMENT OF PAUL BIANCHI

Mr. BIANCHI. My name is Paul Bianchi. I have read your bill and I am pleased to say that both myself and the Cooley's Anemia Blood and Research Foundation which has 13 chapters across the United States support this logical approach toward health care in the United States. I would like to ask that our formal testimony become part of the record.

Mr. SCHEUER. Indeed it will [see p. 260].

Mr. BIANCHI. I say that I am happy because my 5-year-old son is a victim of Cooley's anemia. He currently receives about 15 blood transfusions per year and this amounts to 2 gallons of red blood cells annually. The cost of this medical care would be about $6,000 were it not for my medical insurance. I am very fortunate to have adequate coverage in my job but many people are not as fortunate as I am. I might also note that retaining this coverage does limit the parents in the job market due to the preexisting condition clause.

As the years pass and my son gets older, surgical and dental fees and the introduction of new home treatment techniques will be a major medical cost. Sustaining the life of these children can require a range of surgery since the chronic iron overload in their systems, their major problem, will attack any and all vital organs.

The Cooley's Anemia Blood and Research Foundation is concerned that your bill covers the vital needs of our children and their families.

First, as the Hemophilia Society stated, that blood and blood products be specified in the language, including all processing fees on an in- and outpatient basis.

Second, that coverage extend to use and treatment of iron chelators and any equipment required for their use. Some real hope for life is now found in the chelating agent known as desferal, thanks to the past support of Congress, but desferal will be an expensive drug to administer—it is technically experimental and it is expensive and we are not sure if it is covered in this bill.

Third, we are concerned that the eligibility of hospitals be extended to all hospitals that our children are currently being treated at. People find a hospital they like, they feel comfortable with it. It would be a shame if they would have to move to another place simply because they were not covered by some bill.

Finally, Cooley's anemia is a chronic illness, not a catastrophic one and hence our bills are continuous year after year and we cannot afford a yearly deductible type of payment which could result from this bill.

These are my impressions of the bill as a parent and as a representative of the Cooley's Anemia Foundation. We support it wholeheartedly and will help wherever we can to get this legislation passed. We are very happy to know that you care about our children.

Thank you.

[Mr. Bianchi's prepared statement follows:]

STATEMENT OF PAUL J. BIANCHI, NATIONAL LEGISLATIVE CHAIRMAN, COOLEY'S ANEMIA BLOOD AND RESEARCH FOUNDATION FOR CHILDREN, INC.[1]

Mr. Scheuer, Senator Javits, and members of this committee, we are very pleased to testify on the legislative proposals both of you have sponsored. We are very grateful to you for your sponsorship of this legislation which, when passed, will be enormously beneficial to our children.

Both of you gentlemen are on the committees which passed the Control Cooley's Anemia Control Act, and its recent amendment into a comprehensive genetic diseases program, so you know a good deal already about Cooley's Anemia, but because of the vital importance of this legislation, and in order to establish a record for further consideration by the Congress, we submit to you the comprehensive statement made by Senator Edward F. Kennedy about the disease, in the Senate on May 1, 1975.

"Cooley's Anemia is an inherited blood disease characterized by a diminished production of hemoglobin, the substance in red blood cells which enables them to carry oxygen to the tissues of the body. The result of this inadequate production of hemoglobin is a particular form of anemia. Dr. Thomas B. Cooley, an American physician, discovered, and labeled this disease around 1925.

"Cooley's Anemia, also known as Mediterranean anemia or thalassemia major, is found in children whose ancestors were natives to the countries surrounding the Mediterranean Sea. In America, these children are of predominantly Greek and Italian origin, although because of widespread intermarriage the disorder is also found in children of Irish, Scandinavian, Jewish, Oriental, and Turkish descent.

"There are two forms of Cooley's anemia: The severe form: called thalassemia major; and the carrier of trait form, thalassemia minor. The difference between these forms depends on whether the individual has inherited half or all of the genetic code or defective hemoglobin synthesis from his parents. Following Mendelian laws, two carriers of the trait who marry may have the possibility of producing the trait in 50 percent of their offspring, and the disease, Cooley's anemia, in 25 percent of their offspring.

"Individuals with the carrier form of thalassemia minor are not handicapped with any physical defects; in fact the only physical sign or symptom of the trait may be a change in the size and shape of the red blood cells. Individuals with the carrier form of the disorder have normal health. The trait—thalassemia minor—never increases in severity or becomes the severe form of the disease. At present the chief method of detecting the carrier form involves a number of hematologic tests including electrophoresis.

"Thalassemia major is usually detectable during the first year of life; its early signs include pallor, listlessness, loss of appetite, and irritability. An examination of the victim's blood will show changes in the size, shape, and numbers of red blood cells, and a variety of abnormal characteristics in special properties of the blood cells in addition to severe anemia. Individuals with thalassemia major rarely live beyond the age of 20, and from their first year of life have to undergo frequent blood transfusions in order to maintain a blood count sufficient for survival.

The anemia itself is basically caused by a reduction in the rate at which red blood cells are formed in the bone marrow and released to the blood stream. In Cooley's anemia, these defective red blood cells do not survive more than one-third to one-half of the life span of normal red blood cells. There is often an enlargement of the spleen which causes further complications in the rate of blood cell production. The anemia created from this low rate of production leads to severe handicaps in its young victims.

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[1] The Cooley's Anemia Blood and Research Foundation for Children, Inc., is the only national, voluntary, nonprofit organization concerned solely with the disease called Cooley's Anemia. The Foundation is an active member of the American Association of Blood Banks, the Ad Hoc Committee to establish an American Blood Commission, and the Hemolytic Anemia study group sponsored by the National Heart and Lung Institute. Also, the Foundation maintains contact with other organizations concerned with the problems affecting Cooley's Anemia victims. For further information contact Mr. P[illegible] J. Bianchi, National Legislative Chairman, 63 Dartmouth Street, Garden City, New York 11530, telephone (516) 437-5052.

Children suffering from this disease tend to be small for their age because bone growth is poor. In addition, they suffer malformed bone development leading to brittle, easily broken bones. The child afflicted with Cooley's anemia cannot usually engage in strenuous physical activities since the anemia causes fatigue.

There is no known cure for Cooley's anemia. At present the only effective treatment is supportive therapy such as the administration of blood transfusions to alleviate the constantly recurring anemia. Some children require transfusions several times a week; some very rarely.

There are no statistics available on the exact number of cases of Cooley's anemia in the United States. It is estimated though that there are approximately 200,000 individuals in this country who are carriers of the trait.

The treatment for thalassemia is thus time-consuming and expensive, both in materials and in the use of skilled manpower. It is available without direct cost and only the tiny minority of patients who happen to be living in a community which provides specialized medical treatment. Most thalassemia patients live in areas distant from transfusion services and hospital staff skilled in the transfusion of small children; in other places where the service is available, the cost is prohibitive for all except the wealthy. And when all the effort has been made, most patients will still die in adolescence and few will live beyond the age of 21 years.

We would like to stress, sadly, that last statement—"few will live beyond the age of 21 years." It is for this reason that your bill is of crucial importance to our concerns, as nearly 100 percent of the patients who have this disease will be covered by the programs.

Comprehensive treatment programs for our children are extremely costly, both as to blood products and their transfusion. We know, by surveys of our families, that many have more than one child with the disease, and each child frequently requires more than $2,000 per year in blood services just to keep alive.

We have read your bill, and have the following comments to make:

(2) *The finding and declaration of purpose.*—We believe that your assertion is correct, that this type of bill is a logical first step toward our goal of a universal health care program in the United States. We would, of course, prefer a national health insurance scheme such as that posed by Senator Kennedy, which would give us an all embracing health care program, especially inasmuch as there may be the possibility in the near future of some kind of breakthrough which would permit the patients currently with this disease to live longer than the age of 18, at which point it will be necessary to have some kind of comprehensive program to take care of them.

(3) *Free choice by patient and practitioner.*—This is vital to us since so many of our patients currently go to a physician that they have been working with for some time and whom they trust. Consequently, we are very much in favor of this particular kind of program.

(4) *Observance of religious beliefs.*—We agree totally with the statement that nothing in this act shall interfere with the religious beliefs of citizens. We are especially concerned that nothing in this legislation be understood to indicate that the Federal Government will be involved in any way in a proposed program of abortion or abortion counseling.

As to section (102), "Eligibility of Benefits," we are agreeable to this legislation which would provide from birth to the age of 18 years and for all pregnant women.

We would prefer at this time not to deal with the administration of the program but concentrate on the various provisions as they would affect us specifically.

Section (20) "Standards for Qualified Institutions." In regard to this section, we would want to make sure that centers that are or might be established for the care of Cooley's Anemia patients would be qualified as institutional providers under this act.

As to the benefits to the children themselves, we would agree with the element of section (211) which deals with "Covered Professional Services," section (212) which deals with "Covered In Patient Hospital Services," section (213), "Covered Nursing Home Services," section (214) "Covered Home Health Services," section (215) "Covered Diagnostic Services."

We are generally in agreement with section (216) which covers "Rehabilitation, Social, and Mental Health Services," with the exception that we would express our concern about the psychiatric and psychological services and social work services being limited to sixty visits annually, as the language of the bill states "in an organized setting." Our concern is that given the nature of the disease, and the way some parents look at the disease, it may well be difficult for families to be treated in group therapy as might otherwise be the case.

We would like to comment no section (217), the "Covered Drugs and Biologicals" as well, simply because there is no other indication here as to whether blood is included. We are hopeful that you can include blood and its derivatives and components under this particular section (this seems to be the only section where such inclusion could be made). Of course, for our patients, payment for blood is vital. If we are forced, as we so often are now, to provide volunteers to give blood in order to have the transfusions made, much of our time and energy are taken up with just this task. Thus, there would be less time available to care for the child.

Additionally, in regard to Part 3 concerning maternity benefits, you should know that we support these particular provisions that you have set forth.

Generally, those are the comments that we have to make about the bill. We support it wholeheartedly as a Foundation and pledge ourselves to do anything within our power to see that this legislation will pass. It cannot come soon enough for us or our children.

We will be pleased to answer any questions.

Mr. Scheuer. Thank you very much.

Miss Bennett, do you have a headquarters in Carnarsie?

Miss Bennett. Yes.

Mr. Scheuer. Thank you all for your statements.

Our final witness will be Dr. Peter Rogatz. Identify yourself for the record and then we will look forward to hearing you.

STATEMENT OF PETER ROGATZ, M.D., PETER ROGATZ AND DONALD MEYERS ASSOCIATES, INC.

Dr. Rogatz. I am Dr. Peter Rogatz. I am a principal in the health care consulting firm of Peter Rogatz and Donald Meyers Associates. My background is as a hospital executive, a medical school planner and administrator, and a Blue Cross executive.

I appreciate the opportunity to talk with you. The thoughts I want to offer are somewhat in contrast to the last several speakers in the sense that they had some very specific tangible issues to bring to your attention, whereas I want to bring to you attention issues that are somewhat more global.

Let me say at the outset that I support the proposed legislation, but I support it with some caveats. I think the legislation exemplifies the dilemma that we face in trying to provide health services in this country today. I think it is a constructive step but does not deal with the ultimate dilemma.

It goes without saying that the major determinants of health in this country are not what we call medical services. I think these determinants have to do with adequacy of income, personal behavior, employment, housing, nutrition, education and environment. I recognize that this bill has a more specific focus—the delivery of medical services.

I do think, however, that we have overvalued medical services for their own sake. We are facing an extraordinary increase in the costs of health care. The bill recognizes this and seeks to control these costs by limiting the reimbursement rates for units of medical service. It uses the device of prospective reimbursement for institutional services.

I think prospective reimbursement represents a significant improvement over the reimbursement originally adopted for medicare which is retrospective. It uses the device of negotiated fees for individual providers (physicians) and I believe that that, too, represents a significant improvement over the prevailing practice in medicare. However, I don't think that reimbursement of unit costs by itself will do the job. I endorse that kind of reimbursement limitation but I would like to point out that in some respects it may even be counterproductive unless it is linked with control of resources.

I would identify three basic premises which I think are probably familiar to you. First, the mere existence of medical resources—hospitals, physicians, nursing homes—tends to encourage their use.

Second, when such resources coexist with a population that has substantial entitlement to medical services, you almost have a guarantee that the resources will be used.

Mr. SCHEUER. You mean as a funding mechanism.

Dr. ROGATZ. Precisely. You almost have a guarantee.

Mr. SCHEUER. Most of these premises are well established.

Dr. ROGATZ. Yes, indeed.

Third, if the resources exist in oversupply in association with entitlement, then you have an almost certain guarantee that they will be overused.

So reimbursement limits on the one hand are valuable because they encourage providers to practice economies and to control unit costs; on the other hand, they fail to deal with overservicing. In my judgment overservicing is probably where the most significant cost savings can take place. I cannot give you hard data, only intuitive judgments, but in terms of controlling unit costs I don't think the savings are great. I think that one can contain the per diem cost at a given hospital to a limited extent without doing harm to quality of care; beyond a certain point limitation of per diem costs will do such harm.

On the other hand, I think the savings that could be realized by eliminating unnecessary medical services may be as much as a third of all the units of care that are provided—be they hospital days, hospital admissions or doctors' services. This is not intended to suggest that the practice of medicine is fundamentally fraudulent or carried out on the basis of venal objectives. I don't mean this.

I mean merely that in our culture we have educated doctors to believe that their services contribute greatly to the health of people and we have educated people to think that they do. When we create a situation where there is unhampered access, we are going to get overservicing and we are going to get a substantial escalation of costs, the kind of escalation which today is causing so much concern.

Mr. SCHEUER. Dr. Rogatz, maybe you could take us from the general to the specific. We are very sensitive to the whole business of costs. I am conducting a series of hearings on the House side on medicaid fraud. I have already got several bills in the hopper on that. I really don't think we have to elaborate much on the general danger of providing service and providing funding apparatus. We are quite well aware of that.

Will you take us by the hand and lead us from the general to the specific and tell us what kinds of devices we can create to deter silly, frivolous use of the system—unnecessary over stressing of the system. This is what we have to know, this is the bottom line.

Dr. ROGATZ. I will try to do that, Congressman Scheuer. I think that the Health Resources Planning and Development Act is a substantial step forward. It at least creates a broadly representative agency in every region responsible for looking at rational deployment of resources. What I believe needs to be done is to give the Health Systems Agencies, and the State agencies to which they provide their findings, a greater degree of power—in effect, the power to decertify facilities and resources when necessary.

Now the obvious difficulty is identifying which facilities should be decertified. Many hospital administrators will concede that there are surplus facilities, surplus beds, but no administrator will concede that any localities in his or her hospital are surplus.

I believe that in any region on locale, a concensus on this vital question can be reached only when that region is faced with the need to finance its health services out of a finite "pot" of money. I have thought a great deal about it and wondered about it and worried about it. I believe that any given area of the country, whether we are talking about a city, a county, a metropolitan area——

Mr. SCHEUER. A region perhaps.

Dr. ROGATZ. Whatever and however it may be defined, that any given region must be confronted with the fact of life that resources are finite. If a given region, in its wisdom, working through a representative body—perhaps designed the way the Health Systems Agency is—decides that it wants to put a CAT scanner in every hospital and pay a price, such as lack of adequate primary care service—which I happen to think is far more important than putting a CAT scanner in every hospital—if that region understands its choices and understands that it really must work with a finite "pot" of money, then let them design whatever health services they want.

I think some regions will make mistakes. Fortunately, in this country we have enough diversity to be able to make mistakes and learn from them. I would like to see individual regions, communities or jurisdictions carry out a variety of different experiments. From such experiences I think we can learn what kind of approach would make most sense nationally.

Mr. SCHEUER. So you would have medical expenses by region and also nationally.

Dr. ROGATZ. By implication, nationally as well, but I think the creation of regional limits would offer suitable protection against the national impact on GNP.

Mr. SCHEUER. Would you address yourself to this bill?

Dr. ROGATZ. Yes, sir. There are several specifics in the bill that I would like to comment on.

Mr. SCHEUER. Let me ask you this before you go to the bill. I agree with your philosophy that there is a good deal to be said on providing a regional budget and regional CAP's. The local community can then make decisions as to whether they want to spend for senior citizens, for kids or for capital construction or for services or more community clinics or more tertiary hospitals. There are a whole variety of choices that have to be made.

Right now, children comprise about a third of the population, yet we spend only 10 percent of our health dollars on them. We are spending well over five times as much per capita for our over 65 population as we are spending for our 18 and under population. Would you say that given a CAP for total health expenditures we ought to spend proportionately more for the under 18 population per capita than we are spending for 18 to 65 or the 65 and over?

Dr. Rogatz. My personal preference would be to increase spending for children: I thoroughly endorse the intent of the bill because I do believe that children are clearly the most valuable national resource we have. I think that national legislation can and should address the question and I think this effort is very much in the right direction.

Given that fact and given a national effort to eliminate financial barriers to access for children and for pregnant women, I would still say that a particular region or area should be free to decide—notwithstanding Federal legislation that would provide specified benefits for children—or for people over 65—that in its own area major emphasis will be given to developing certain specific resources at the expense of others. I would preserve each region's right to do what it thinks is best although some regions undoubtedly will make mistakes, because I think the results of such "experiments" would be valuable to the country as a whole and because I think there may be special regional needs that transcend any national norms.

Mr. Scheuer. What kinds of differences are there on a regional basis?

Dr. Rogatz. Those regions of the country where older people have tended to congregate presumably would require a heavier than average concentration of such resources as extended care facilities, home health services, and so on. By contrast, urban ghetto areas, where I would expect the number of children per capita to exceed the national average, would require more emphasis on primary services such as the EPSDT (early and periodic screening diagnosis and treatment) programs.

Mr. Scheuer. Can you envisage a situation where because elderly people vote very heavily and kids under 18 don't vote at all that the political clout of the elderly people might result in expenditures being made to them far exceeding any reasonable relationship to some kind of overall or fair assessment of need?

Dr. Rogatz. Of course, I could envision such a situation. I am not wise enough to know how to deal with that. That goes to the fundamentals of the political process; I would not like to admit it but I think I am over my head there.

Mr. Scheuer. I think we are all over our heads but maybe that is why we have a Congress.

Dr. Rogatz. I do hope that Congress can be responsive to the broader national needs regardless of some of these parochial pressures and I do think the proposal legislation is clearly an effort to do that.

Mr. Cutler. How do you insure that the provider domination is not what occurs with respect to how the dollars will be distributed? The system has always worked that way—the more powerful forces if there is a fee schedule, it is always going to be more dominant within the provider itself.

Dr. Rogatz. I think it is clear that even when we develop planning bodies with a composition like the health systems agencies which are technically consumer dominated, providers are able to exercise a degree of leverage out of proportion to their numerical representation on the board. I don't believe we can or should completely eliminate provider influence. However, with only a finite amount of money available in any one region, I am not as worried about the impact of provider domination of decisions as I would otherwise be.

Where there is only so much money to go around, I am less concerned about the danger of hospitals, physicians, nursing homes or any provider group getting a disproportionate share for itself. Decisions as to allocation of funds would pass through a more or less representative body which would readily come to understand that if it decides in favor of unrestrained reimbursement to physicians, such a step could be taken only at the cost of reduced financial aid for hospital services, dental care or some other element of health services.

I don't think the public has yet faced up to the implications of a finite supply of health dollars and this may be the best way to get the public to understand. The Congress is beginning to face up to this, but, until some kind of real hard resource allocation takes place on a local level, I think we are going to see a continuation of the cost escalation process.

Mr. SCHEUER. I think there is some consensus among some of us that more resources ought to go into neighborhood and ambulatory care units. I am not sure that the hospital power elite or the medical power elite would agree.

Dr. ROGATZ. I think that is right, Congressman Scheuer.

Mr. SCHEUER. I am not sure it is right.

Dr. ROGATZ. During the initial years one has to expect that it will take some time for the public representatives on these resource allocation bodies to become sophisticated enough to deal with all the issues, but one does not have to be too sophisticated to know that if the region has only so many millions of dollars to spend on health care during a specific period of time, the region has got to start making some hard choices. That is where I think public sophistication and wisdom has to start. I don't think we could be worse off than we are today with the kind of understrained cost escalation that exists. I think the public must understand that certain tradeoffs are essential and must accept responsibility for deciding itself what kinds of tradeoffs it wants to make.

Mr. CUTLER. What concerns me, Dr. Rogatz, it that those who have will get more and those that have not, still don't have a piece of the action, will be getting much less in the long run; to wit, the patient. I mean if the hospital is—let's look at New York City. You don't see the municipals staying open. The municipals are staying open but the power boards of trustees are the ones that are staying in existence.

Dr. ROGATZ. We have not yet put New York City, or to the best of my knowledge any other city, to a test of the kind that we are speaking about now, where a given political or geographic jurisdiction has said, "That is all there is for the next 2 or 3 or 4 years; there is no more. Start to do some planning." When that happens it is true that the powerful institutions will quickly pull the wagons into a circle and defend their own particular bailiwicks but they will for the first time find the public saying, "Well, gee, if there is only so much money maybe"—I hate to pick on the CAT scanner all the time but that is what today's——

Mr. Scheuer. It is sort of symbolic.

Dr. Rogatz. Today's symbol. Last year or several years ago it was open heart surgery.

Mr. Scheuer. Or kidney dialysis. You pay $25,000 or $30,000 a year to keep a person in their 70's or 80's going as against providing ambulatory outpatient facilities for kids. I mean where is the cost benefit? These are some agonizing decisions that have to be made.

Dr. Rogatz. They are the ultimate decisions and in some respects I believe they can be made and should be made best at the local level. This is not to deny wisdom at the Federal level but at the Federal level we now have entitlement for victims of chronic kidney disease and we have entitlement for people over 65. If the legislation we are now discussing comes into being, as I hope it will, we will have entitlement for children. There will be more demand for reimbursement than can be met by any finite pot of money. The alternatives are either to plan rationally, as to the distribution of funds to be determined by an irrational scramble among providers.

Mr. Scheuer. You are going to have to have a rationing process.

Dr. Rogatz. You have to have. I think it is extremely difficult to develop that rationing process exclusively at the Federal level. I think the process might work better by obliging each locality or region to make its own judgments and resource allocations.

Mr. Scheuer. We had an interesting decisionmaking process in the EPSDT, the early periodic screening diagnosis and treatment program, which is probably as cost effective a program as you will ever find in treating health problems for kids at an early stage in their lives. The rationing process was that the Federal Government had the money and just did not spend it.

Today out of 13 million kids who should have been screened, less than 2 million have been and the problems that were divulged by that screening for the most part remain untreated. So I agree with you that neither the zeal nor the concern nor the decisionmaking process at the Federal level seems at all satisfactory. Probably the most cost effective health service we have may be family planning that has a cost benefit ratio that is off the chart. It has been inconceivably downgraded by the Federal Government.

A third of our counties have no family planning services at all. We passed a bill in 1970 of which I was the House author whereby we said we would provide federally assisted family planning services for every woman in her child-bearing years in 5 years and we are now in our 6th year and we still have 3.5 million women to go. So I would say you are absolutely right, there is no empirical evidence that this kind of decisionmaking authority and this kind of rationing will be carried out.

Dr. Rogatz. I think it can only work if the allocations are made at a level lower than the Federal Government. The lower it gets, the more likely we are to develop public understanding of the issues and public demand for the kinds of services that make most sense—EPSDT, family planning, and so on.

There are one or two specific points that I would like to comment on in the bill. I am referring here to S. 2593. In section 202 reference is made to the fact that a qualified hospital needs to have an annual occupancy rate of at least 75 percent. Such a requirement may contribute a temptation to a hospital to inflate its occupancy rate. Now a hospital that has an occupancy rate of 50 percent may not be able to inflate it to 75, but one whose occupancy rate is 72 percent may well be able to.

Mr. SCHEUER. What should be outpatients.

Dr. ROGATZ. Yes; or extending the length of stay if it takes only a fractional increase in average length of stay to bring an occupancy of 65 percent up to 75.

Mr. SCHEUER. I put a letter in the Congressional Record from a hospital administrator for a very large and well known hospital in this city, a prestigious hospital. It was a letter from the hospital administrator to all attending physicians and in effect he said, "Look, we are in a cost bind and in order to maintain the standard of quality care we must keep our patient count up and so, boys, let's please send them in."

Dr. ROGATZ. I have seen documents of that kind.

Now in section 211 the legislation speaks of a second consultation. Fine. I think, however, that some basic level of surgical qualification should be required of the surgeon providing the second opinion. I also believe it would be appropriate to extend this second opinion beyond T and A, to cover all elective surgery. As you may know, Blue Cross and Blue Shield of Greater New York instituted such a plan several months ago.

Mr. SCHEUER. For all elective surgery.

Dr. ROGATZ. For all elective surgery. It will take a while before the results can be known. There were obviously serious objections raised by some.

Mr. SCHEUER. By whom?

Dr. ROGATZ. Some in the medical profession who thought it was not necessary. On the other hand, some surgeons have been very supportive of the idea.

Mr. SCHEUER. How about the medical societies and the College of Surgeons and so on?

Dr. ROGATZ. I am not able to tell you from memory what specific positions were taken. In general, I would say the organized elements of the profession were at least acquiescent, if not supportive.

Mr. SCHEUER. That is very encouraging.

Dr. ROGATZ. There are obviously wide differences of opinion.

Mr. SCHEUER. Talking about Blue Cross and Blue Shield, you had experience working in that arena. Could you take us to the mountain top and tell us as we progress toward either a national health insurance program or this maternal child health law we are looking at, what you see as the role for the insurance companies, as against perhaps the Federal Government or the States in administering these programs?

Dr. ROGATZ. That obviously gets into another very large complex area. In general I can't speak with any authority about the private insurance companies as opposed to Blue Cross since I had relatively little experience with the commercial companies. My experience with Blue Cross has been that its intermediary role, in my judgment, has been carried out quite well. I think, in terms of cost effectiveness and general efficiency, it has been a well performed role.

There are obviously criticisms one can make and we have all heard those criticisms. It is a complicated effort that the Blue Cross system has been embarked on. It has not been done perfectly but I was impressed, having come into the Blue Cross system without any prior commitments to it, and having left it with no residual commitments to it, I am impressed that the system has done the job well. I do not see the idea of a major Federal agency delegating an intermediary role as an unreasonable way to go. I don't think it is the only way, but I think it is a perfectly reasonable way. As a country we have a significant investment in Blue Cross expertise.

Mr. SCHEUER. Can you see a possibility of creating perhaps a pluralistic system that tries in some areas the commercial route and the Blues while others use the Federal or the State government as intermediary?

Dr. ROGATZ. I think on an experimental basis it makes sense to see which of several different systems works better.

I would like to call another thing to your attention if I may, Congressman Scheuer, concerning section 222, which makes reference to inpatient services for pregnant women. There is an experiment recently initiated by Blue Cross and Blue Shield of Greater New York and the Maternity Center Association in New York City to provide obstetrical services on an ambulatory basis. That has been very controversial with the support in some circles of the medical profession and vociferous opposition in other circles. I think it is too early to judge whether that experiment will bear out the appropriateness of this form of care but it is an experiment that deserves watching.

Mr. SCHEUER. We heard some very interesting testimony today from this group.

Dr. ROGATZ. I didn't know that they testified but I am glad that they did.

Mr. SCHEUER. We will send you a copy of their testimony and you will be able to read it.

Dr. ROGATZ. I would appreciate it.

Mr. SCHEUER. Thank you very much for your very helpful testimony. The hearing is hereby adjourned.

[The following letter was received for the record:]

THE CITY OF NEW YORK,
OFFICE OF THE COMPTROLLER,
New York, N.Y., September 13, 1976.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, Washington, D.C.

DEAR CONGRESSMAN ROGERS: The proposed Maternal and Child Health Act, H.R. 14822 would provide not only a significant improvement in health care for mothers and children, but also a more equitable and rational method of financing such care. I am pleased to give this proposal my enthusiastic support.

As New York City's chief fiscal officer, I estimate that as much as $100 million annually is spent from the City's budget for the maternal and child health care of its citizens. This expenditure, to the extent it achieves its objectives, is a sound and necessary investment in the health of future generations of Americans.

and their ability to become productive citizens. But it is an investment which cities like New York are finding it increasingly difficult to make in the face of depressed economies and declining tax bases. If there is not a restructuring of the cost, the outlook for maintaining even the present level of health care for pregnant women and infants is exceedingly bleak.

The proposed bill, as its sponsors suggest, would be an important step toward a universal health insurance program, providing useful experience with respect to cost and the effectiveness of measures to prevent abuse. In this connection, I urge inclusion of the strongest possible safeguards against fraud in order to avoid a repetition of the deplorable abuses under Medicaid.

I congratulate the sponsors of H.R. 14822 and thank the Subcommittee for giving New Yorkers the opportunity to be heard in its support.

Sincerely,

HARRISON J. GOLDIN, *Comptroller.*

[Whereupon, at 3:50 p.m., the hearing adjourned.]